American Optometric Association
NEWS™

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Health system in Md. to cover OD eye care for employees

The Shore Health System (SHS), a major provider of hospital services along Maryland's Eastern Mid-Shore and the region's largest employer, will soon cover medical eye care services provided by optometrists under its Employee Retirement Income Security Act (ERISA)-qualified employee health plan, according to the Maryland Optometric Association (MOA).

"This is of monumental importance to optometric practices on the Maryland Shore. The SHS has over 2,000 employees and is preparing to expand into a regional health system as part of the University of Maryland Medical System," said Alan S. Bishop, O.D., who has been working with SHS administrators in an effort to ensure continuity of care for his patients who are employees of the hospital system. "Obviously, we are very pleased with this development."

The SHS Benefits Committee voted to include optometrists as providers under its employee health plan last month following a series of discussions to clarify the role of optometrists as providers of primary eye care as well as vision care, according to Greg Bartoo, the administrator for Dr. Bishop's Easton Eye Care. Bartoo contributed to the discussions.

The SHS benefits committee acted on a recommendation from its employee health plan's third-party administrator, Innovative Health Services (IHS). That recommendation was the result of talks between Dr. Bishop and the IHS Executive Team, including the company's medical director, on how optometric care could provide improved outcomes at lower costs.

See Maryland, page 11

Hopping urges ODs to move forward after favorable ABO ruling

AOA President Ronald Hopping, O.D., MPH, issued a statement in response to the ruling in favor of the American Board of Optometry (ABO) in the false advertising lawsuit brought by the American Optometric Society (AOS).

"As you will note, the judge ruled in favor of the ABO. This ruling is seen as support for the six forward-thinking professional organizations (ASCO, AAO, ARBO, AOSA, NBEO and the AOA) that saw the need for board certification for our profession and who designed and recommended the board certification program to the ABO. I compliment those optometrists who voluntarily serve as ABO leaders for their successful defense of optometric board certification.

"I think the next steps our profession takes are critical. As I said in my acceptance speech, 'I am proud of this House, and the other associations in this profession, for making a proactive decision (supporting board certification). Now we have much bigger challenges ahead of us. We can wallow in this board certification turmoil while the rest of the world moves forward or, if we are going to be successful, we can move on. We must move on. We have much bigger challenges ahead of us.'

From left, John Greenberg, lead attorney for the ABO; Les Walls, O.D., M.D., ABO witness; David Heath, O.D., ABO board member; David Cockrell, O.D., AOA vice president and ABO board member; Paul Ajamian, O.D., chair of the ABO board; Jeff Weaver, O.D., ABO executive director; and Kent Munson, ABO co-counsel, are shown after the ruling in favor of the ABO in the false advertising lawsuit brought by the AOS.

"Following this clear judicial ruling, I ask for your help in turning a new page for our profession, and for your help in healing our profession. I welcome the participation of every optometrist in moving our profession forward. Our

see Ruling, page 18

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AOA campaign boosts optometry awareness

The AOA is continuing to boost optometry awareness across the country. In May and June, the Optometry Awareness & Public Affairs Campaign team continued to position the AOA and doctors of optometry as the go-to source among top-tier media for stories on eye health and vision, focusing on timely topics such as ultraviolet (UV) protection.

Other important campaign milestones included fielding the 2012 American Eye-Q® consumer survey.

This helped the public awareness team gain valuable insights into the public's knowledge and perceptions regarding eye health and vision issues.

The survey results will be used throughout the year in media outreach efforts and relationship-building opportunities with key media.

The campaign also prepared for the launch of the annual Ready for School campaign. This year's campaign, along with other ongoing efforts, will help enhance optometry's reputation by promoting awareness and understanding of who optometrists are and how they help patients.

May highlights, accomplishments

May saw several significant media coverage, including:

❖ *Shape* magazine's May issue covered computer vision syndrome and quoted the AOA and the State University of New York State College of Optometry.

The magazine reaches 1.5 million readers.

❖ *Ebony* magazine's May column "Prescription for good health: Dr. Dave's advice on how to keep every part of your body in tip-top condition," garnered 1.2 million audience impressions.

It refers to the AOA when offering tips on "Your Vision."

❖ *Parenting* magazine's May issue featured "Protect Those Peepers." The article quoted AOA trustee Andrea Thau, O.D., and reached 2.2 million audience impressions.

June highlights, accomplishments

Earlier this summer, the campaign garnered attention in major media outlets.

❖ The June issue of *Parents* magazine included information from the AOA in its "Health News" section.

In the article, AOA Immediate Past President Dori Carlson, O.D., stated, "3-D movies can help detect vision problems in children. If your child fidgets with their 3-D glasses, covers an eye, or complains of eye discomfort, dizziness or a headache during the film, take them for an eye exam."

Parents magazine has a circulation of more than 2.2 million.

❖ *Prevention* magazine featured information on nighttime driving from Dr. Thau.

The "Ask Prevention" section of the June issue of *Prevention* magazine included this question from a reader: "I find it hard to see well driving at night, though I see fine by day. Does anything help?"

The response informed readers: "Even people who don't wear glasses can have trouble seeing lane demarcations, dips in the road, and more when driving in the dark. Some of these hazards—as well as the glare of headlights from oncoming cars—can be mitigated by keeping the inside and outside of your windshield free of dust and smears," advised Dr. Thau.

Prevention magazine has a circulation of 2.9 million readers.

❖ The AOA and AOA members prominently featured in a high-profile "Healthy Vision & Hearing" supplement to *USA Today*.

The special June section included three AOA/AOA-member bylined articles and statistics from the AOA scattered and referenced throughout the nine-page supplement.

To lead off the special section, Dr. Carlson bylined the article "Think about your eyes," reminding consumers that protecting vision should be an important part of the overall health care routine for Americans of all ages.

AOA Associate Director of Public Relations Susan Thomas and AOA member Fraser C. Horn, O.D., were quoted multiple times in an article titled "Let the sun shine in, but always (always) wear sunglasses," regarding UV protection.

Additionally, AOA member Glenda B. Secor, O.D., bylined an article on contact lenses and their ability to offer improved visual acuity and an enhanced quality of life.

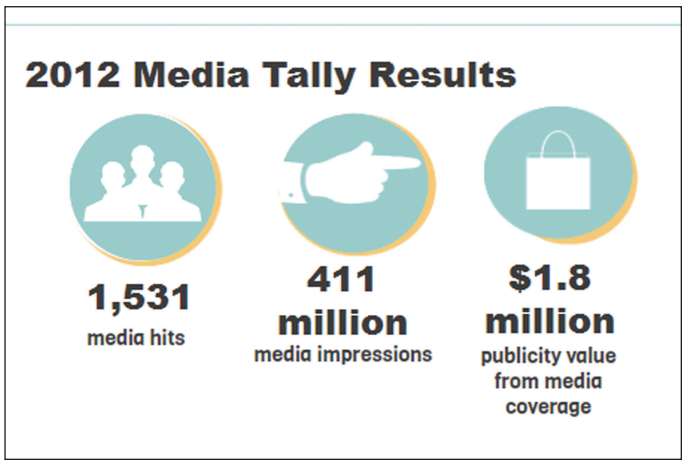
Finally, the last article in the supplement titled "Healthy eating, healthy eyes" was authored by the AOA. The article included information about nutrition and vision, highlighting the particular benefits of omega-3s.

The "Healthy Vision & Hearing" supplement was inserted in 1.6 million editions of *USA Today* across the country.

❖ During Optometry's Meeting® in Chicago, AOA member James Sheedy, O.D., Ph.D., was interviewed by NBC-affiliate WMAQ-TV, which aired on Friday, June 29, about 3-D and eye health.

The segment was a follow-up to the blockbuster Opening General Session on 3-D at Optometry's Meeting®.

The "Healthy Vision & Hearing" supplement was inserted in 1.6 million editions of USA Today across the country.



Hall of Famers

Shown from left are Optometry Hall of Fame inductees Frank Fontana, O.D., from Missouri; James A. Boucher, O.D., from Wyoming; Thomas L. Lewis, O.D., Ph.D., from Pennsylvania; Kevin Alexander, O.D., Ph.D., from California; and William "Billy" Cochran, O.D., DOS, from Tennessee. At top left is Illinois College of Optometry President Arol R. Augsburger, O.D.

The National Optometry Hall of Fame, administered by Optometry Cares® —The AOA Foundation, inducted these five new members into the elite group of optometrists during a ceremony at Optometry's Meeting® in June. The National Optometry Hall of Fame highlights the luminaries within the field of optometry—individuals who have made a significant and long-lasting impact on the profession. New inductees are determined by a selection committee that represents the AOA, Association of Schools and Colleges of Optometry (ASCO); the College of Optometrists in Vision Development (COVD); the National Optometric Association (NOA); and the American Academy of Optometry (AAO).

American Optometric Association

243 N. Lindbergh Blvd.
St. Louis MO 63141
800-365-2219
www.aoa.org

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AOA News Staff
www.aoanews.org

Tracy Overton
MANAGING EDITOR
TLOVERTON@AOA.ORG

Bob Pieper
SENIOR EDITOR
RFPIEPER@AOA.ORG

Matt Willette
WASHINGTON DC EDITOR
MWILLETTE@AOA.ORG

Laurie Bergman
SOCIAL MEDIA MANAGER
LWBERGMAN@AOA.ORG

Bob Foster, ELS
ASSOCIATE DIRECTOR,
PUBLISHING/SOCIAL MEDIA
RAFOSTER@AOA.ORG

Sandra Lundgren
COMMUNICATIONS & MARKETING DIRECTOR
SMLUNDGREN@AOA.ORG

Barry Barresi, O.D., Ph.D.
EXECUTIVE DIRECTOR
BJBARRESI@AOA.ORG

Advertising

Display Advertising
Aileen Rivera
Advertising Sales Representative
Elsevier
360 Park Avenue South
New York, NY 10010-1710
212-633-3721
Fax: 212-633-3820
A.RIVERA@ELSEVIER.COM

Classified Advertising
Traci Peppers
Advertising Sales Representative
Elsevier
360 Park Avenue South
New York, NY 10010-1710
212-633-3766
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Getting wrapped up

One of the important lessons I recently learned is that if you are invited to a White House meeting you should fly in the night before just in case your flight is delayed. I've never been delayed flying into Washington, so I saw patients another day and thought I'd fly in that morning for the afternoon meeting. As you may suspect, my plane had mechanical problems and was delayed for several hours. Fortunately, I was able to talk myself onto another flight and arrived at the White House with eight minutes to spare. Of course, trying to get through federal security quickly was another matter, but my lesson was learned.

The reason I was flying to Washington was because your American Optometric Association was invited, along with other physicians groups, to participate in a White House discussion on health care reform. There were about 120 of us in the White House meeting, and certainly it is a tribute to the essential role of optometry and the AOA in the health care debates that Dori Carlson, O.D., and I were invited.

The educational discussion was hearty, and everyone had something to say about health care reform in this country—how quality will be judged and what changes to make in patient care. As I participated in that White House meeting, it was again very clear to me that health care is literally re-forming itself throughout this country, and many parts of health care change are already in place. Health insurance for young adults, small business tax credits, and payment initiatives based on perceived quality are here now. No matter how the November elections come out—and as proven by the recent Supreme Court decision—dramatic health care reform, and experimentation, will continue to occur in this nation.

It is also very clear to me that we cannot stop these changes. No one, no association, no business, no government agency can turn the clock back to where we were when my father practiced. And no matter what we might want, no one can throw out an anchor and keep things the same as today. Change will occur, and we must adapt. The AOA must be there to help our members adapt.

It is clear optometry must maintain our independence, for without our independence we become pawns.

This meeting also reinforced to me what I already knew. Optometry's future will be wrapped up in accountable care organizations, in patient-centered medical homes, in bundled payments, in enhanced care organizations, in health information exchange technologies, in electronic portals, and in the very critical quality- and value-based payment systems. And our future will be wrapped up in as yet unknown changes, and unknown systems, in our nation's health care.

Yet throughout all these revolutionary changes, I firmly believe optometry will continue to be a valuable and essential contributor to our nation's health. Optometry provides the overwhelming amount of eye care in this country, and the demographics of our nation's population are clear. As our nation ages, even more optometric services will be needed. However, we are certainly not in for a free ride. Other strong forces outside our profession, and there are many, have other plans for us – and their plans are not anything you or I are going to like. As we look forward, some things are very clear to me. It is clear optometry must maintain our independence, for without our independence we become pawns.

We must assure our patients' access to our care,

We must be allowed to deliver patient care at our highest level of training and ability,

We must continue to be recognized as physicians,

We must be fully integrated as primary health care professionals in our nation's health care system, and

We must be paid fairly and equally for equal care, equal service, and equal responsibility.

I promise you, these are the goals and the battles the AOA has planned for, is committed to—and that we must win.

During my presidential acceptance speech, the question I asked each of us was:

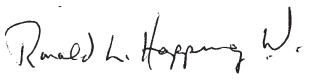
Dr. Hopping

"What future will we write?" Or should the question be: "What will others write for us?"

There are many things, many difficult things, we must do if we are to write our own future, and we will talk about those in the days to come. But today, the first question to answer, for each of us throughout our profession, members and nonmembers, is: "Will we do the things needed to write our own future?" Will we be a member of the AOA and our affiliate? Will we support AOA-PAC and our state PACs? We will be a Keyperson for our legislator? Will we control our own practices, will we stay informed and involved?

If your answer is yes, then we will write our own future.

This year I ask each of you for your help. I need your help in fighting these battles. And I promise to always fly into Washington, D.C., the day before for a White House meeting.



Ronald Hopping, O.D., MPH
AOA president

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Onward. Upward.

AOA Next Generation Optometry

eXcel™

www.ExcelOD.com

AOAExcel™ site offers unique resource for ODs

Optometrists, like just about everyone else, are now accessing goods and services online; however, they have never before had an online resource like AOAExcel™, according to Joe E. Ellis, O.D., AOA past president and chair of the new wholly owned AOA subsidiary that launched the new website last month.

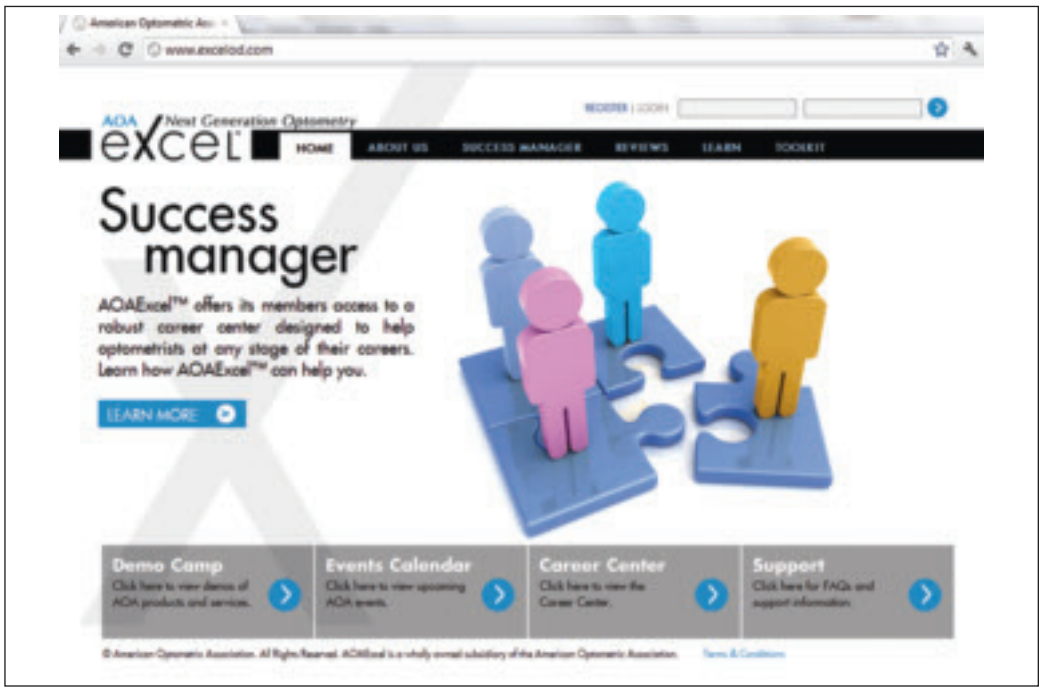
Make www.ExcelOD.com your practice's homepage or select it as a "favorite" for easy access.

"The AOAExcel™ website (www.ExcelOD.com) is unprecedented in the array of services it offers optometrists." Dr. Ellis said. "Optometrists seeking practice management education, career guidance, financial services, insurance coverage, marketing strategies, professional opportunities, or coding/billing resources will now be able to find it all conveniently online at one site. Starting in early 2013, AOAExcel™ will launch XNetwork, providing direct access to health information technology (HIT) cloud-based products and connectivity services with other health providers.

"Moreover, to assist practitioners in easily navigating the site, AOAExcel™ offers recommendations on services or content, based on whether a practitioner is entering practice, midcareer, or looking forward to retirement," Dr. Ellis said.

Prominently featured on the AOAExcel™ homepage are:

- The AOAExcel™ Success Manager, which offers direct access to a range of placement, financial and insurance services
- AOAExcel™ Reviews, featuring practitioner reviews of products and services for optometric practices
- The AOAExcel™ Learning Management System, which offers easy access to EyeLearn™, the AOA's optometric continuing education portal, and
- The AOAExcel™ Toolkit, which will soon offer practitioners the opportunity to pick from a list of online practice management solutions that can be used to optimize practice operations, improve patient care and optimize third party reimbursement payments



Other features include the AOAExcel™ Events Calendar, a listing of major meetings and other events of interest to optometrists.

Additional features will be added to the website on a regular basis, Dr. Ellis said.

"We hope that all AOA members, as well as their office personnel, will take a few minutes to visit ExcelOD.com over the coming weeks and explore all of the products and services it offers," Dr. Ellis said. "We also hope optometrists will revisit AOAExcel™ regularly to find out about new offerings."

Because he believes many optometrists will visit the site regularly, Dr. Ellis suggests practitioners consider making *www.ExcelOD.com* the homepage for their office computer systems or selecting the website as a "favorite" to facilitate easy access.

AOA members can log onto AOAExcel™ by entering their AOA member number and password in the boxes at the upper right corner of the website home page.

Nonmembers can obtain a limited-time guest registration on the site that includes multiple messages promoting the value of AOA membership.

Some states now offer ODs Medicaid EHR incentives

Optometrists in five states can now participate in Medicaid Electronic Health Records (EHR) Incentive Programs – with optometrists in up to a half-dozen more possibly becoming eligible for Medicaid EHR incentives in the near future, according to the AOA Advocacy Group.

Since the Medicaid EHR Incentive Program was created under the American Recovery and Reinvestment Act (ARRA) of 2009, Alabama, Illinois, Kentucky, Ohio and South Carolina have all amended their Medicaid State Plans to allow optometrists to qualify for EHR incentives.

Under the Medicaid EHR Incentive Program, health care practitioners who demonstrate that they have billed at least 30 percent of their insurance claims to Medicaid during a 90-day reporting period can qualify for up to $63,750 in incentives over the six-year life of the program. The Medicare EHR Incentive Program, by comparison, offers up to $44,000 ($48,400 in federally designated Health Professional Shortage Areas).

The entry of optometrists into state Medicaid EHR Incentive Programs comes as the result of lobbying efforts by the AOA to get the Centers for Medicare & Medicaid Services (CMS) to clarify incentive program rules, as well as successful efforts by state optometric associations to assist state Medicaid departments in filing necessary state Medicaid plan amendments with the CMS to allow participation by optometrists in their incentive programs.

An article in the May edition of *AOA News* incorrectly indicated ODs were not yet authorized to participate in Medicaid EHR incentive programs in any states.

For more information, see "Five states now offer Medicaid EHR incentives to ODs" in the April edition of *AOA News* or contact Brian Reuwer in the AOA Washington office at 800-365-2219, ext.1343 or *BReuwer@aoa.org*.

Medicare regulatory reform effort under way

The Centers for Medicare & Medicaid Services (CMS) on May 10 finalized two rules to reduce unnecessary, obsolete, and/or burdensome regulations on American hospitals and health care providers.

"These rules will help achieve the key goal of President Obama's regulatory reform initiative to reduce unnecessary burdens on business and save approximately $1.1 billion across the health care system in the first year and more than $5 billion over five years," CMS officials said in a prepared statement.

The two sets of regulatory reforms, published last month in the *Federal Register*, are designed to improve transparency and help providers operate more efficiently and at lower cost by reducing their regulatory burden, CMS officials said.

One set finalizes updates to the Medicare Conditions of Participation (CoPs) for hospitals and critical access hospitals (CAHs). The second set, the Medicare Regulatory Reform rule, addresses regulatory requirements for a broader range of health care providers and suppliers who provide care to Medicare and Medicaid beneficiaries.

> *"By reducing unnecessary burdens on health care providers, this rule allows them to dedicate more resources to improving patient care."*

The Medicare Regulatory Reform rule will identify and begin to eliminate duplicative, overlapping, outdated, and conflicting regulatory requirements for health care providers and suppliers, including hospitals, ambulatory surgical centers, end-stage renal disease facilities, durable medical equipment suppliers, and a host of other health care providers and suppliers regulated under Medicare and Medicaid.

The goal of this final rule is to both reduce regulatory burdens and help providers improve care for patients.

"By reducing unnecessary burdens on health care providers, this rule allows them to dedicate more resources to improving patient care," CMS officials said.

Some of the more than two dozen finalized regulatory changes include:

- **Re-enrollment Bar for Providers and Suppliers.** The new rules eliminated a Medicare "re-enrollment bar" for providers and suppliers who have had billing privileges revoked solely for failure to promptly respond to a CMS revalidation request or similar request for information.

Federal regulation (42 C.F.R. § 424.535), designed to protect Medicare from unscrupulous providers, allows the CMS and its payment contractors to revoke the billing privileges of health care practitioners and product suppliers who provide Medicare with inaccurate enrollment information or fail to update enrollment information in timely manner.

Since 2008, the CMS has barred all such practitioners and providers from re-enrolling in the Medicare program for one to three years after their billing privileges were revoked.

"(W)e believe that this change is appropriate because the re-enrollment bar in such circumstances often results in unnecessarily harsh consequences for the provider or supplier and causes beneficiary access issues in some cases. We have learned of numerous instances where the provider's failure to respond to a revalidation request was unintentional; that is, the provider was not aware of the request due to, for instance, misrouted mail or a clerical mistake," CMS officials noted in the *Federal Register* notice for the new rule.

Practitioners and suppliers who have billing privileges revoked for more serious reasons (for example, a felony conviction) can still be barred from re-entering the program for an appropriate period of time, the CMS emphasized.

- **Appeals of Part A and Part B Claims Determinations**. The CMS has removed obsolete regulations, developed prior to the 2000 federal Benefits Improvement and Protection Act (BIPA), governing initial determinations, re-openings, and appeals of claims under original Medicare. "This will eliminate confusion by Medicare beneficiaries, providers, and suppliers regarding which appeals rights and procedures apply," CMS officials said.
- **E-prescribing.** The CMS has also retired older versions of e-prescribing transactions for Medicare Part D and adopted newer versions to be in compliance with the current e-prescribing standards.

The CMS estimates the Medicare Regulatory Reform rule could save up to $200 million in the first year and over $100 million in each year thereafter.

"Taken together, (the hospital and practitioner regulatory reform) rules will reduce hospital and other health care provider costs by more than $1.1 billion the first year. These cost savings will come directly from reduced regulatory burdens, and are not accompanied by reimbursement reductions. As such, these savings will help providers improve the quality of care they provide to Medicare and Medicaid beneficiaries and all Americans," according to the CMS statement.

The final rules were developed through a retrospective review of existing federal regulations called for by President Obama's Jan. 18, 2011, Executive Order 13563 to "modify, streamline, or repeal" regulations that impose unnecessary burdens, including those on hospitals and other providers that must comply with requirements through Medicare.

The rules take into consideration numerous burden reduction recommendations from hospitals, CAHs, members of Congress, and patient advocates, among others. In total, the CMS considered more than 1,800 comments from members of the public in finalizing these rules.

To view the final rules, visit *www.ofr.gov/inspection.aspx*.

Medicare now sending all RA in 5010 format

Effective Aug. 1, 2012, the Medicare Fee-for-Service program is issuing all electronic remittance advice (RA) to health care practitioners in the new X12 Version 5010 software format, according to the U.S. Centers for Medicare & Medicaid Services (CMS).

That means health care practitioners who have not yet converted their practice software systems from the old Version 4010 to the new Version 5010 format may not be able to open and read their Medicare remittance advice to review payments, adjustments, and denials, or even post payments to patient accounts, the CMS noted.

Any health care practitioners who have not yet converted their office software to the 5010 format should do so, the CMS advises. Those who utilize a claims clearinghouse or billing service, and have not checked already, should ensure the service has implemented 5010 software.

Practitioners who begin experiencing problems in opening or translating Medicare remittance advice on or after Aug. 1 should contact their software vendors, clearinghouses, or billing services, before contacting area Medicare payment contractors about the problem, the CMS said.

Any billing staff or representatives who make inquiries related to Medicare payment on behalf of a practitioner will need a copy of the practitioner's remittance advice, the CMS noted.

For additional information on Medicare's conversion to the Version 5010 software format, see the AOA website 5010 page (*www.aoa.org/5010*).

AOA to Congress and Obama administration: Act now to avert looming Medicare pay cut

While work continues to ensure that ODs and patients are treated fairly under health care reform, the AOA and other physician organizations are now placing increased pressure on Congress and the Obama administration to find the equitable solution needed to avert a massive Medicare pay cut set to take effect at the end of this year.

Without corrective action, ODs and other physicians will see a nearly 30 percent reduction in Medicare reimbursement rates starting Jan. 1, 2013.

Knowing the pitfalls of these drastic reductions or even the uncertainty from the threat, the AOA is now urging Congress and the administration to act quickly to protect patients and providers from these potentially disastrous cuts.

Leading the charge, Dori Carlson, O.D., then-AOA president, and Ron Hopping, O.D., then-AOA president-elect, presented a united front for optometry in early June at a special White House meeting with U.S. Department of Health & Human Services Secretary Kathleen Sebelius, Obama administration health policy officials, and representatives of other physician groups.

At the invite-only meeting, which mainly focused on health care payment and delivery reform, Drs. Carlson and Hopping used the extraordinary opportunity to provide optometry's perspective on care coordination and quality issues and emphasized the essential role that optometrists play in providing primary care and the need to eliminate health plan and other barriers to patient access to full-scope optometric care.

"If policymakers are serious about reducing costs and finding increased efficiency, America's doctors of optometry must be viewed as a key part of the solution."

"Doctors of optometry have historically been and continue to be providers of first-contact care for basic health services that are needed by most or all of the population as optometrists perform needed eye examinations for the overwhelming majority of Americans," Dr. Hopping said.

"Doctors of optometry are among the only primary care health care professionals many relatively healthy patients see, and as a result, optometrists continue to play a critical role in the delivery of primary and systemic preventive care and serve as a critical entry point into America's health care system," Dr. Hopping said.

"As our health system changes and we make strides toward a quality-enhancing payment mechanism, the AOA believes that efforts must be focused on increasing access to services that ultimately decrease the need for costly procedures," Dr. Hopping added.

"While optometrists are primary care providers for essential vision and eye health services that often reduce the need for costly interventions, many new payment and delivery models either exclude or fail to value the key role that doctors of optometry play in reducing overall costs through improved access to preventive and primary care services as well as increased provider competition in the health care marketplace," added Dr. Hopping.

"The reality is that, in practice, many secondary and tertiary providers rely on primary eye care management provided by optometrists, but top-down policies too often discourage these efficient approaches and transitions developed locally. While optometrists stand ready to provide further help, policymakers would be well-served to not let old biases and misplaced motivations derail overall efforts to increase quality and reduce health care costs," Dr. Hopping concluded.

As Drs. Carlson and Hopping were providing a united front for optometry at the White House, the AOA was also making its voice heard on these issues on Capitol Hill.

In response to a direct request from U.S. House Ways and Means Committee Chairman Dave Camp (R-Mich.), the AOA reinforced optometry's key role in efforts to promote value-based measures and practice arrangements that can improve health outcomes and efficiency.

In comments delivered directly to Ways and Means Committee members and staff, AOA again stressed that the drive to transform the current Medicare payment system must be focused on increasing access to services that ultimately reduce the need for costly procedures down the road rather than limiting access to certain services based on old biases and misplaced motivations.

AOA President Ron Hopping, O.D., MPH, and Immediate Past President Dori Carlson, O.D., in front of the Eisenhower Executive Office Building on the White House grounds.

"Optometrists are motivated to participate in efforts to improve quality and efficiency and we believe that we bring a unique perspective because optometrists are primary care providers for essential primary care vision and eye health services that reduce the need for preventable and costly interventions," the AOA said in a detailed response to Chairman Camp and members of the Committee.

"As you move forward, AOA urges the committee to remember that previous efforts to manage care and costs failed because utilization was restricted based on non-medical reasons. If policymakers are serious about reducing costs and finding increased efficiency, America's doctors of optometry must be viewed as a key part of the solution," the letter said.

Among other issues addressed in the AOA's comments, the committee was also reminded that AOA members continue to experience discrimination in some Medicare policies merely because of where the optometrist went to school, and this causes enormous and unnecessary burdens for ODs who wish to provide care they are trained and licensed to do, and unfairly limits patient access to needed care.

"Medicare should not limit the care that optometrists are state-licensed to provide – care that optometrists legally provide to non-Medicare patients – merely because of the opinion of some policymakers about the value of the educational degree that optometrists hold," the AOA asserted.

With a massive Medicare pay cut scheduled to take effect at the end of the year and ongoing efforts to transform health care delivery and payment, ODs and optometry students are urged to join the AOA's ongoing advocacy in the nation's capital by contacting the AOA Washington office team at 800-365-2219 or *ImpactWashingtonDC@aoa.org*.

Patients with bacterial conjunctivitis have a need for speed.

They want their symptoms to go away fast. Getting bacterial conjunctivitis under control promptly can help prevent the spread of infection—and get patients back to their normal daily routines.[1]

After 3 days of dosing in a clinical study, MOXEZA® Solution provided[1,2]:

- Overall microbiological success in ***75% of patients***
- Clinical cure in ***63% of patients***

Patients should always be instructed to follow the full course of 7-day therapy.

Indications and Usage:
MOXEZA® Solution is a topical fluoroquinolone anti-infective indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms: *Aerococcus viridans*, Corynebacterium macginleyi*, Enterococcus faecalis*, Micrococcus luteus*, Staphylococcus arlettae*, S. aureus, S. capitis, S. epidermidis, S. haemolyticus, S. hominis, S. saprophyticus*, S. warneri*, Streptococcus mitis*, S. pneumoniae, S. parasanguinis*, Escherichia coli*, Haemophilus influenzae, Klebsiella pneumoniae*, Propionibacterium acnes, Chlamydia trachomatis** (*efficacy for this organism was studied in fewer than 10 infections).

Dosage and Administration:
Instill 1 drop in the affected eye(s) 2 times daily for 7 days.

IMPORTANT SAFETY INFORMATION
Warnings and Precautions:

- Topical ophthalmic use only.
- Hypersensitivity and anaphylaxis have been reported with systemic use of moxifloxacin.
- Prolonged use may result in overgrowth of non-susceptible organisms, including fungi.
- Patients should not wear contact lenses if they have signs or symptoms of bacterial conjunctivitis.

Adverse Reactions:
The most common adverse reactions reported in 1-2% of patients were eye irritation, pyrexia, and conjunctivitis.

For additional information please refer to the accompanying brief summary of prescribing information on adjacent page.

References:
1. Tauber S, Cupp G, Garber R, Bartell J, Vohra F, Stroman D. Microbiological efficacy of a new ophthalmic formulation of moxifloxacin dosed twice-daily for bacterial conjunctivitis. *Adv Ther*. 2011;28(7):566-574.
2. MOXEZA® Solution package insert.

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MAKE IT
Moxeza®
(moxifloxacin HCl ophthalmic solution) 0.5% as base

Alcon®

Maryland,

from page 1

"We found SHS receptive to our presentation," Bartoo said.

Critical to the policy change was a letter from the MOA to SHS Benefits Committee Chair Michael Zimmerman outlining the contemporary scope of optometric practice under Maryland law and the educational requirements for optometrists in the state.

Misunderstandings regarding the role optometrists now play as primary eye care providers are still common among many health plan administrators, Bartoo said.

AOA Third Party Committee member Peter M. Agnone, Jr., O.D., and AOA Third Party Center Director Lendy Pridgen worked with Dr. Bishop to initiate "a very successful dialogue" with the plan administrators, Bartoo said.

The AOA also provided information for the letter to the SHS benefits committee.

"This is good example of how practicing optometrists can win coverage for their eye care services under employee benefit programs by working with plan administrators," Dr. Agnone said. "The AOA Third Party Committee can provide a wealth of advice on arranging and conducting such meetings. The AOA also offers materials specifically designed for presentation to plan administrators."

As the AOA, MOA and other affiliates at the state level continue to advocate for ODs to be defined as primary care eye care providers, "this is an excellent step in the right direction," said Jennifer Levy, director of Legislative Affairs at the MOA, who was instrumental in facilitating the productive dialogue among the parties.

Bartoo added, "Obviously, we are very pleased with the development, and we could not have represented the interests of our patients and our optometric colleagues without the coordinated support from the MOA and AOA. There simply is not a more beautiful portrayal of team work in action!"

AOA members interested in pursuing coverage for their eye care services under employee benefit plans should contact Pridgen in the AOA Third Party Center at *TPC@AOA.org*.

Send letters to:

Editor, AOA News
243 N. Lindbergh Blvd.,
St. Louis MO 63141
TLOverton@aoa.org

The AOA News reserves the right to edit letters submitted for publication.

LETTERS

Drivers, 'eye exam'

Dear Editor:

I want to thank Dr. Carlson for her column on "Lessons learned as president." I have also learned that patients have confused their last eye exam with a Motor Vehicle Department eye test. It is precisely because of this confusion that our doctors will only fill out Motor Vehicle screenings for our active and current patients. Any other individual requesting the "eye exam" for their driver's license is directed to one of our licensed opticians for that simple acuity test.

Too often, I have seen patients with advanced glaucoma, diabetic retinopathy, and a host of other ocular diseases untreated because they thought they already had a comprehensive exam instead of just an acuity test.

It is exactly because of this reason that only our opticians administer the driver's license exam to individuals who are not our patients. Our doctors also need to protect their rears as well as their patients' eye health.

Roy B. Cohen, O.D.
New York, N.Y.

Board certification side effects

Dear Editor:

I grew up on the Wisconsin side of Lake Michigan. It could be the hottest day in August, but getting acclimated to the icy cold water always was a time-consuming, borderline painful process. I recently took the American Board of Optometry (ABO) certification exam, and there are some definite parallels. Preparation was time-consuming and taxing. I took a KMK review course and found its review book and online quizzes very helpful. For someone like me, who took his last optics course in the early 1970s, a lot of reviewing was needed.

I know there are very strong opinions on both sides of this issue. The examination does involve a considerable amount of preparation time. What I do notice is that I am a better optometrist as a result of the preparation. The learning process helped clarify some issues I was unclear about, I relearned some things I had forgotten about, and I learned many useful items I could apply to patient care. To know whether all the learning will help prevent Alzheimer's disease, check with me in a decade.

Joseph Ruskiewicz, O.D., MPH, Salus University, private practice, Pottstown, Pa.

Send letters to:

Editor, AOA News
243 N. Lindbergh Blvd.,
St. Louis MO 63141

TLOverton@aoa.org.

***AOA News* reserves the right to edit letters submitted for publication.**

'Vision Problems in the U.S.' data show sharp increase in eye disease prevalence

More adult Americans are facing the reality of eye disease than ever before. According to the 2012 update of the "Vision Problems in the U.S." report, a study by Prevent Blindness America and the National Eye Institute, the number of those ages 40 and older with vision impairment and blindness has increased 23 percent since the year 2000.

The study, conducted by researchers from Johns Hopkins University, provides prevalence rates and estimates cases of age-related eye conditions.

A full version of the study is available at *www.preventblindness.org/vision-problems*.

In addition, a preliminary update to the 2007 Prevent Blindness America "Economic Impact of Vision Problems" report shows a $1 billion increase in costs of excess medical care expenditures, informal care and health-related quality of life related to visual impairment and blindness.

Further cost information is being developed and a full updated report on the economic impact of vision problems will be available at a later date.

Overviews of both reports were presented at the Prevent Blindness America "Focus on Eye Health Summit" in Washington, D.C., for which the AOA was a sponsor. The summit also featured a number of other key public health updates and presentations from national leaders, including reports on eye health surveillance efforts and NEI planning activities for vision research.

Statistics from the 2012 "Vision Problems in the U.S." report on the four most common eye diseases highlight alarming increases since 2000, including:

- 2,069,403 people age 50 and older have late age-related macular degeneration (AMD), a 25 percent increase
- 24,409,978 million people age 40 and older have cataracts, a 19 percent increase
- 2,719,379 million people age 40 and older have open-angle glaucoma, a 22 percent increase
- 7,685,237 million people ages 40 and older have diabetic retinopathy, an 89 percent increase.

> *"What is exceptionally concerning is the dramatic spike in diabetic retinopathy cases, a consequence of the diabetes epidemic that this country is experiencing with no end in sight."*

"It's no surprise that the numbers of those affected by eye disease are continuing to climb, especially due to the aging baby boomer population," said Hugh R. Parry, president and chief executive officer of Prevent Blindness America. "What is exceptionally concerning is the dramatic spike in diabetic retinopathy cases, a consequence of the diabetes epidemic that this country is experiencing with no end in sight."

Diabetes is the leading cause of new cases of blindness in adults 20 to 74 years of age.

According to the Centers for Disease Control and Prevention, diabetes affects 25.8 million people in the United States.

Although there is no cure for diabetic eye disease, annual eye exams for diabetes patients are essential to help slow the progression of the disease.

All data from the "Vision Problems in the U.S." report can now be obtained through a new searchable database housed on the Prevent Blindness America website at *www.preventblindness.org/vision-problems*.

This unique tool enables users to research a wide range of information including eye disease and condition numbers broken down by state, age, sex, and race, and provides comparisons across disease conditions.

"It is our hope that this new data will provide those in the health community, the public and our nation's leaders with the vital information they need to address these troubling numbers through programs, research and funding," said Parry.

For more information about the 2012 "Vision Problems in the U.S." report, the Prevent Blindness America "Focus on Eye Health: A National Summit," diabetes and other eye diseases, visit *www.preventblindness.org* or call 800-331-2020.

Data from the report can be accessed on the PBA website (*www.visionproblemsus. org*).

U.S. Virgin Islands legislature approves expansion of optometric scope of practice

On July 18, 2012, U.S. Virgin Islands Gov. John P. de Jongh, Jr. (D) signed Act 7376 into law expanding the scope of practice for optometrists by authorizing the use of diagnostic drugs and the prescription of certain topical and oral drugs to diagnose and treat eye disease.

The U.S. Virgin Islands becomes the largest of the U.S. territories or commonwealths to expand the scope of practice for optometrists since legislation was enacted in the territory of Guam authorizing diagnostic pharmaceutical agents (DPAs) in December 1982 and therapeutic pharmaceutical agents (TPAs) in April 1995, and in the Commonwealth of Puerto Rico authorizing DPAs in August 1999.

There are approximately 110,000 residents in the U.S. Virgin Islands and fewer than a dozen practicing optometrists.

"Similar to laws passed in the first wave of expansion efforts in the U.S. states through the 1970s and 1980s, this act represents a good first effort by the optometrists in the U.S. Virgin Islands to expand the scope of services they are able to provide their patients," said Bobby Jarrell, O.D., who is chair of the AOA State Government Relations Committee. "We congratulate them on their success."

The act authorizes the following:

- Diagnostic drugs defined to include cycloplegics, mydriatics, anesthetics, and fluorescein.
- Topical legend drugs (excluding allergens, alpha adrenergic agonists, antiparasitics, antifungal agents, antimetabolites, antineoplastics, beta adrenergic blocking agent, carbonic anhydrase inhibitors, collagen corneal shields, epinephrine preparations, miotics used for the treatment of glaucoma, temporary collagen implants, and succus cineraria maritime).
- Oral legend drugs defined to include antibiotics, antihistamines, antivirals, and non-narcotic analgesics.
- Removal of foreign bodies that have not perforated the Bowman's membrane.

Specifically excluded from the scope of practice are:

- Treatment of glaucoma; surgery; use of injectable drugs; prescription of controlled substances; treatment of the lacrimal drainage system or lacrimal gland; X-ray; photocoagulation; ionizing radiation; or treatment of structures posterior to the iris, but treatment of iritis will be allowed.

In addition, the act mandates that candidates for initial licensure must now pass the three-part examination series administered by the National Board of Examiners in Optometry.

IU's optometry, medicine schools announce exchange program with eye institutes, hospitals in India

Indiana University (IU) Schools of Optometry and Medicine are creating a new academic exchange program, the Indo-U.S. Exchange Program for Optometry and Ophthalmology, with four eye institutes and hospitals in India.

The two-year pilot program will provide the opportunity for IU School of Optometry residents to enhance postgraduate training with a monthlong trip to eye institutes and hospitals in Chennai, Mumbai and Hyderabad, India. In turn, eye care professionals from participating institutions in India will spend one month in the United States visiting the IU School of Optometry in Bloomington and the Glick Eye Institute at the IU School of Medicine in Indianapolis.

"This collaboration will provide important opportunities for our students to expand their training horizons and for IU to develop its network of relationships within India, a critical educational partner," said IU Provost and Executive Vice President Lauren Robel.

The new exchange program builds on IU's growing academic relationship with educational and research institutions in India.

"This exchange program will provide expanded educational opportunities for IU School of Optometry residents," said IU School of Optometry Dean Joseph A. Bonanno, O.D., Ph.D. "They will encounter large numbers of ocular disorders, especially those that are uncommon in the U.S. They will also see, first hand, alternative approaches to high-volume health care."

Dr. Bonanno added that this type of exchange program is unique to optometric residencies and therefore is expected to attract individuals looking for a diverse experience.

Eight eye care professionals from India and eight IU optometry residents will participate in the exchange program during the first two years, at which point additional optometry and ophthalmology institutions within the United States will be invited to join the IU program.

"The new exchange program's mission is to develop an understanding between the participants of the level of training and scope of practice of U.S. and Indian optometrists and ophthalmologists while also providing opportunities to enhance clinical training and research opportunities."

Students from India are already working in biochemistry, biology and physics labs at Indiana University (IU) this summer through the Khorana Scholars Program. Through a new exchange program initiated by IU, optometry and ophthalmology students at IU and in India will be offered new educational and research opportunities. Khorana scholars pictured above are, clockwise from back left, Divya Ganapathi Sankara, Sachin Sethi, Priyadarshina Ravindran, Niveditha Damodaren, Devanshi Khare and Swati Varshney.
Photo courtesy of Indiana University

optometrists and ophthalmologists while also providing opportunities to enhance clinical training and research opportunities," said Sarita Soni, O.D., professor of optometry and vice provost for research at IU Bloomington. "Future goals include the development of a long-term relationship facilitating the exchange of ideas on clinical care and the development of collaborative research in vision."

Participating institutions in India are Sankara Nethralaya, a nonprofit eye institute in Chennai, LV Prasad Eye Institute in Hyderabad, and Hinduja Hospital and Shroff Eye Hospital, both in Mumbai. Principal investigators for IU are Dr. Soni, Jeffrey Perotti, O.D. (IU Optometry), and Louis Cantor, M.D. (Glick Eye Institute).

IU and its Indian partners will provide about 70 percent of the estimated $410,000 cost of the two-year pilot program, with the Indo-U.S. Science and Technology Forum providing the remaining support.

"This new Indo-U.S. exchange initiative in optometry and ophthalmology between Indiana University and Indian eye care institutions is a welcome development," said Gullapalli N. Rao, chair of the LV Prasad Eye Institute. "This will facilitate a broad range of collaborations in education and research that can potentially lead to enhancing the quality of education, as well as addressing bigger research questions. This initial phase of interaction will pave the path to these endeavors, so we are excited about this opportunity of working with our colleagues at Indiana University."

The Indo-U.S. Science and Technology Forum, established under an agreement between the U.S. and India governments, is a not-for-profit society that promotes Indo-U.S. collaborations in science, technology, engineering and biomedical research through interaction among government, academia and industry.

New Merck IOP-lowering drug now available

Merck announced the availability of the first preservative-free, fixed-dose combination therapy for lowering elevated intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension who are insufficiently responsive to beta-blockers. The treatment, COSOPT PF (dorzolamide hydrochloride-timolol maleate ophthalmic solution), a carbonic anhydrase inhibitor with a beta-adrenergic receptor blocking agent, was approved by the Food and Drug Administration on Feb. 1, 2012.

COSOPT PF has been proven to provide the same powerful efficacy as original COSOPT.

In an active-treatment controlled, parallel, double-masked study in 261 patients with elevated IOP ≥22 mmHg in one or both eyes, COSOPT PF had an IOP-lowering effect equivalent to that of COSOPT.

The IOP-lowering effect of COSOPT twice daily was greater (1–3 mmHg) than that of monotherapy with either 2.0% dorzolamide three times daily or 0.5% timolol twice daily.

The IOP-lowering effect of COSOPT twice daily was approximately 1 mmHg less than that of concomitant therapy with 2.0% dorzolamide three times daily and 0.5% timolol twice daily.

Prescribing information is available at *www.merck.com* or by calling 800-672-6372 or contacting a Merck representative.

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Nebraska's See to Learn® program provides free vision assessments for preschoolers

To address health care cost barriers for children and ensure preschoolers have a vision assessment before starting school, the Nebraska Optometric Association (NOA), Nebraska Foundation for Children's Vision, and the Eye Care Council work together by offering the See to Learn® program.

As a result, more than 11,000 3-year-old children across Nebraska have received free vision assessments since 1997.

According to Alissa Johnson, associate director/director of communications for the NOA, "The program's goal is to increase the proportion of children ages 5 years and under who have visited an eye care provider in the preceding 12 months. Preschool vision assessments are important enough that NOA members provide them for free through the See to Learn® program."

In support of Nebraska's See to Learn® program, a $3,500 Healthy Eyes Healthy People® (HEHP) grant was recently awarded to offset all See to Learn® expenses, including promotional activities, advertising and customizable tools for participating NOA-member ODs.

The NOA and the Nebraska Foundation for Children's Vision promote free See to Learn® assessments to parents, caretakers, educators, day care providers and others in the community through activities ranging from newspaper ads, press releases and brochures, to emails, postcards and other promotional materials.

In addition, NOA members are kept informed through See to Learn® conferences, phone calls and regular communications.

> *"Twenty percent of children entering kindergarten have an undetected vision problem, and this number increases to more than 30 percent by the time those children graduate from high school."*

"Twenty percent of children entering kindergarten have an undetected vision problem, and this number increases to more than 30 percent by the time those children graduate from high school," Johnson explained.

Good vision is critical to learning, yet young children often don't realize they cannot see, and typical pediatric screenings don't detect many problems.

"To catch vision disorders before the first year of school, Nebraska's participating See to Learn® optometrists provide free vision assessments for any 3-year-old, regardless of economic status," said Johnson.

Congratulations to the NOA for receiving a HEHP grant for the Nebraska See to Learn® program.

To learn more about the See to Learn® program, visit *www.seetolearn.com* or *www.nechildrensvision.org*.

October is Nebraska's See to Learn® month

While Nebraska optometrists double their efforts to help children in October, See to Learn® is a national, year-round program where optometrists provide free vision assessments for 3-year-old children to help make sure they have the necessary visual skills to perform to their academic potential.

Optometrists also work to educate parents and others about the warning signs of vision problems in children of all ages.

Parents of 3-year-olds are encouraged to call 800-960-EYES to find a participating See to Learn® optometrist in their area and schedule a free assessment.

See to Learn® promotional materials

- Educational Brochures (English and Spanish)
- Visual Health Cards
- Vision Care Records*
- See to Learn® Bear Bookmarks
- See to Learn® Bear Stickers
- See to Learn® Bear Coloring Sheets
- See to Learn® Notepads

**Featuring the AOA's Optometric Clinical Practice Guideline for Recommended Examination Frequency for the Pediatric Patient*

Share news from your state with the profession! Contact Sue Chiles at schiles@aoa.org.

These See to Learn® doctors make a difference in Nebraska children's lives

Terry Adams, O.D., Scottsbluff
Ginny Ahrens, O.D., Omaha
Steve Alcorn, O.D., Fremont
Edgar Alderman, O.D., Minden
Karen Armitage, O.D., Omaha
Mark Arneson, O.D., Lincoln
Andrew Bateman, O.D., Lincoln
John Bateman, O.D., Plattsmouth
Jeremiah Baumfalk, O.D., Lincoln
Kim Baxter, O.D., North Platte
Deborah Bessler, O.D., Crete
Mark Blackledge, O.D., North Platte
Brandon Blair, O.D., Ord
Bradley Blumenstock, O.D., O'Neill
Tamara Bonnes, O.D., Grand Island
Jeff Brewer, O.D., Omaha
Brian Brightman, O.D., Lincoln
Courtney Brightman, O.D., Roca
Richard Brown, O.D., Grand Island
Richard Bunger, O.D., Grand Island
Gregory Burrows, O.D., Benkelman
Tim Burrows, O.D., McCook
Timothy Chancellor, O.D., Chadron
Cheryl Chapman, O.D., Gretna
Paul Colburn, O.D., Scottsbluff
John Crotty, O.D., Auburn
Karen Culbertson, O.D., Omaha
James Devine, O.D., Lincoln
James Dickey, O.D., Chadron
Matthew Dinslage, O.D., Columbus
Nancy Dob, O.D., York
Mindy Dorsey, O.D., Ord
Desinee Drakulich, O.D., Omaha
Donald Ediger, O.D., Lincoln
Evan Evans, O.D., Ainsworth
Ann Feidler-Klein, O.D., Norfolk
Will Ferguson, O.D., Omaha
Janet Fett, O.D., South Sioux City
Roger Filips, O.D., Hartington
Scott French, O.D., North Platte
Jennifer Furstenau, O.D., Pierce
Larry Garrett, O.D., Gothenburg
Teri Geist, O.D., Omaha
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Richard Haney, O.D., Columbus
Ted Harvey, O.D., Lexington
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Joshua Hopkins, O.D., Wayne
Chad Hudnall, O.D., Grand Island
Christa Hunnicutt, O.D., Aurora
Brett Hytrek, O.D., Holdrege
Abigail Jackson, O.D., Omaha
Natasha Jenkins Long, O.D., Scottsbluff
Jeffrey Johnson, O.D., Fairbury
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Jonathan Knutson, O.D., Lincoln
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Jeffery Kozal, O.D., Kearney
Kerry Krings, O.D., Platte Center
Jaimie Kruger, O.D., Omaha
Marsha Kubica, O.D., Omaha
John Lange, O.D., Lincoln
Wendi Langel, O.D., Omaha
Dawn Langford, O.D., Grand Island
Corey Langford, O.D., Omaha
Jason Langford, O.D., Grand Island
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Christopher Wolfe, O.D., Omaha
Darren Wright, O.D., Auburn

NOA Nebraska Optometric Association

NEBRASKA FOUNDATION FOR CHILDREN'S VISION

Ruling,

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future now depends on what we all do together," Dr. Hopping said.

Other organizations also offered statements:

ASCO President David Heath, O.D., said, "As ASCO is one of the founding organizations of the ABO, committed to the development of a professional and valid board certification program for the profession, I am gratified that the decision of the court was so clear. This is truly a transformative decision, which helps optometry to move forward as an integral partner in the greater health care system. I sincerely hope this decision will allow all members of our profession to move the conversation and the process forward with civility and unity."

NBEO President Nancy Peterson-Klein, O.D., said, "NBEO congratulates the ABO and AOS for reaching a point of resolution concerning board certification. A credible board certification process ultimately benefits the profession and public we serve."

AAO Immediate Past President Mark W. Eger, O.D., said, "I'm very happy the trial is concluded. Hopefully, the judge's decision will put an end to the controversy. It's time for the profession to heal."

Past AOA and ASCO President Kevin Alexander, O.D., Ph.D., said, "Optometry's board certification process grew from the Optometry 2020 Summits; was conceptualized by the Joint Board Certification Project Team made up of six organizations; was discussed in countless meetings and blogs in all 50 states; was endorsed by the AOA House of Delegates and the governing bodies of other major organizations; and, finally has been reaffirmed by a federal judge following a court challenge. Now is the time for everyone to embrace change as optometry approaches health care reform with credentialing tools equal to other professions."

ABO wins lawsuit

Earlier this month, the Honorable Judge A. Howard Matz ruled in favor of the American Board of Optometry (ABO) in the false advertising lawsuit brought by the American Optometric Society (AOS).

The AOS had alleged that the ABO's use of the term "board certification" was confusing to the public. The court disagreed.

The court entered its ruling at the close of the plaintiff's case; therefore the ABO was not even required to put on a defense.

"This is an historic moment for optometry," said Paul C. Ajamian, O.D., ABO chair of the board. "The judge's ruling will allow the profession to move forward and reunite."

The ABO Board wishes to thank all the optometrists who supported it in this case, as well as the attorneys John B. Greenberg and H. Kent Munson of Stolar Partnership, LLP.

Certified coding staff could help avoid claim audits

With Medicare and other public and private insurance programs stepping up audit and claim review programs, securing prompt payment by avoiding claim errors has become a top priority for many practicing optometrists, according to the Commission on Paraoptometric Certification (CPC).

With that in mind, the CPC introduced its Certified Paraoptometric Coder™ (CPOC) program in 2011, the first coding training certificate program specifically for optometric office staff.

"Recent Medicare reports confirm that claim rejections, denials, and audits are generally the result of common coding errors, failure to provide all of the necessary documentation, or simple clerical errors such as failing to sign forms," said Amy Kraemer, CPOT, chair of the CPOC Examination Development Committee.

Utilization of properly trained and certified coding and billing staff can be an effective way to help ensure steady practice cash flow by making sure claims are coded and filed correctly, according to Kraemer.

"Paraoptometric coders are responsible for ensuring that all of the information about diagnoses and procedures for patients is accurate and complete," Kraemer said. "A certified paraoptometric coder can be the first line of defense against non-compliance and improper coding for the practitioner. Beyond helping to ensure prompt payment of claims, a certified coder can help to maintain compliance with state and federal laws. This is especially important since the government has started focusing on identifying and fining or prosecuting for fraudulent claims."

A certified paraoptometric coder can be the first line of defense against non-compliance and improper coding for the practitioner.

The CPOC program centers on mastery of common health care billing code systems – the American Medical Association's (AMA) Current Procedural Coding® (CPT), the International Classification of Diseases, Ninth Revision (ICD-9), and the U.S. Department of Health & Human Services' Healthcare Common Procedure Coding System (HCPCS) – and the two major reference volumes optometric office staff use to find billing codes and claim-filing rules – the AMA's CPT Standard Edition coding manual and the AOA's Codes for Optometry.

In addition to the coding systems, the program covers anatomy and physiology, medical terminology, medical records, claim filing, and compliance matters.

The coding examination covers both CPT procedure codes and CPT Evaluation & Management (E&M) codes, as well as rules for reporting the proper levels of E&M services on claims.

The CPC's CPOC Handbook for Candidates outlines a course of study on coding and billing.

A new CPOC Study Map provides a list of study resources, links to online materials, and suggested references according to the subject matter.

The AOA Paraoptometric Section has made available Introduction to Insurance Processing Study Flash Cards and more recently, a series of live webinars for billing and coding beginners.

The CPOC examination is open-book and consists of 150 multiple choice questions. Candidates have three hours in which to complete the examination.

The CPT Standard Edition and Codes for Optometry are the only reference books permitted for use during testing.

"The examination is designed not just to test specific knowledge but to make you think about the code book and say: Now where would I find that?" said Kraemer.

The CPOC examination is administered five times each year (in February, May, June, August, and November) at PSI exam locations around the nation and each June at Optometry's Meeting®.

Paraoptometrics can still register for this year's remaining coding certification examinations, which will be administered Nov. 3-17 (registration deadline is Oct. 12).

Applicants must have a minimum of a high school diploma or equivalent, and must have a minimum of two years employment in the medical coding and billing field.

The examination fee is $240.

The 2012 edition of Codes for Optometry and the CPT Standard Edition are both available from the AOA Marketplace online store (*www.aoa.org/x12590.xml*).

For additional information see the AOA Web site CPC page (*www.aoa.org/x4989.xml*).

CPC: 1,027 paras earned certification during 2011

Some 1,027 paraoptometrics achieved entry-level or advanced certification through the Commission on Paraoptometric Certification (CPC) last year, according to the commission's recently released "2011 Year in Review" report. That includes those taking part in the commission's new Certified Paraoptometric Coder™ (CPOC) program (see article on previous page).

In all, more than 6,000 paraoptometrics across the United States, Canada, and on U.S. military bases around the world now maintain certification through the program, the report noted.

The CPC continues to offer the only certfication program developed specifically for optometric office personnel.

The commission offers four levels of certification, coinciding with the levels of responsibility that paraoptometrics are commonly assigned in practices:

- Certified paraoptometric (CPO),
- Certified paraoptometric assistant (CPOA),
- Certified paraoptometric technician (CPOT), and
- Certified paraoptometric coder (CPOC).

Of the 1,027 optometric office staff members who successfully completed CPC certification examinations last year, 693 achieved entry-level certified paraoptometric status, 185 advanced to the certified paraopotmetric assistant level, and 64 became top-level certified paraoptometric technicians.

Thirty-two successfully demonstated proficiency in practice-related skills through the commision's practical exam. Fifty-three received coding certification.

Overall, some 1,162 candidates took CPC examinations last year, with 88 percent passing.

Nine out of 10 (91.5 percent) of the 757 candidates for entry-level CPO certification achieved the required 75 percent passing grade on a 100-question test covering basic science, clinical principles and procedures, ophthalmic optics and dispensing, and professional issues.

Eight out of 10 (81 percent) of the 229 candidates for CPOA certification achieved the required 67.5 percent passing score on a 225-question test covering office operations, ophthalmic optics and dispensing, testing and procedures, special procedures, refractive status of the eye and binocularity, and basic ocular anatomy and physiology.

Nearly nine out of 10 (89 percent) of the 72 candidates for CPOT certification achieved the required 66.8 percent passing grade on a 250-question exam covering pre-testing procedures, clinical procedures, ophthalmic optics and dispensing, refractive status of the eye and binocularity, anatomy and physiology, and practice management.

The CPC continues to offer the only certfication program developed specifically for optometric office personnel.

Ninety-one percent of the 35 paraoptometrics who took the CPOT Practical Examination last year achieved the required passing grades in a three-station exam (case history/ pre-testing, contact lenses/ drop instillation/ blood pressure procedure, and neutralization/ ophthalmic dispensing) covering 170 tasks and related subjects.

Three-quarters (77 percent) of the 69 candidates who took the new CPOC achieved the minimum 70 percent passing grade on a 150-question exam covering anatomy and physiology, medical terminology, the Current Procedural Terminology® coding system, diagnosis codes, paper and electronic medical records, claim filing and regulatory compliance.

Candidates generally scored best on the medical terminology, diagnosis coding, and medical records sections of the tests. They generally posted their lowest score on the claim filing and anatomy and physiology sections.

With the certification program now a decade old, many long-time optometric office staff members have now achieved entry and advanced level certification, CPC staff notes.

Younger and less experienced candidates are sitting for the examinations. As a result, scores for some sections of the tests are decreasing, the CPC report noted.

For that reason, practitioners may wish to review their staff training policies and consider providing more formal education programs for their office personnel, CPC staff suggested.

The AOA Paraoptometric Section offers a variety of both training and continuing education programs. In addition, the AOA Clinical Resources Group has developed several practice resource tools on the AOA website that may be helpful to paraoptometric staff. The AOA Paraoptometric Section offers a column on paraoptometric issues in the *AOA News*.

To be certified at any level, candidates must pass a proctored, written examination. CPOT candidates must also pass a practical examination within three years of the written examination. (Graduates of Accreditation Council on Optometric Education-approved civilian or military optometric technician programs are exempt from the practical examination.)

Candidates for all levels of certification must have a high school diploma or equivalent. Candidates for advanced CPC certification (CPOA, CPOT) must either hold a lower level of certification offered by the commission, be students in a related education program, or meet other eligibility requirements. For each level of certification, the CPC offers a recommended self-study program and optional review course. Candidates for the CPOC exam must have a high school diploma or equivalent and a minimum of two years of medical coding experience.

In addition to the initial certification program, the CPC offers recertification as a mechanism to ensure its certificants remain current in their optometric assisting skills and continue to develop professional expertise through continuing education activities.

In order to maintain certification at any level, the paraoptometric must meet renewal requirements, including 18 hours of documented continuing education over a three-year period. Those renewing a coding certification will need a minimum of nine hours of appropriately related continuing education over a three-year period. Written exams are proctored five times a year (February, May, June, August, November), while the CPOT Practical Examination is offered two to three times at various locations around the country. All examinations (with the exception of the CPOT Practical) are offered during four eight-day testing periods as a computer-based examination. A "paper and pencil" examination is offered in conjunction with Optometry's Meeting®.

AOA and AOA Paraoptometric Section members can access information on CPC certification and paraoptometric training programs at *www.aoa.org/x4932.xml*.

Paraoptometric certification levels

- Certified paraoptometrics (CPOs) must have demonstrated competency in basic optometric office duties. They are tested for proficiency in the areas of basic science, clinical principles and procedures, ophthalmic optics and dispensing, and related professional issues.
- Certified paraoptometric assistants (CPOAs) must have the skills necessary to take on management responsibilities within the office. They must demonstrate proficiency in office operations, ophthalmic optics and dispensing, testing procedures, special procedures, refractive status of the eye and binocularity, as well as basic ocular anatomy and physiology and basic ocular pharmacology. They are also expected to be familiar with all CPO-level subject matter.
- Certified paraoptometric technicians (CPOT) must be able to assist optometrists with a range of patient care functions such as pre-testing or contact lens dispensing. Certified paraoptometric technicians are tested for proficiency in pre-testing procedures, clinical procedures, ophthalmic optics and dispensing, refractive status of the eye and binocularity, anatomy and physiology, as well as practice management. Candidates are also expected to be familiar with all subject matter from the CPO and CPOA examinations.
- Certified paraoptometric coders (CPOC) are responsible for ensuring that all of the information about diagnoses and procedures for patients is accurate and complete. They are tested for proficiency in the Current Procedural Terminology® coding system, diagnosis codes, anatomy and physiology, medical terminology, medical records (paper/electronic), claim filing, and regulatory compliance. Candidates must have a minimum of two years of experience in coding and billing.

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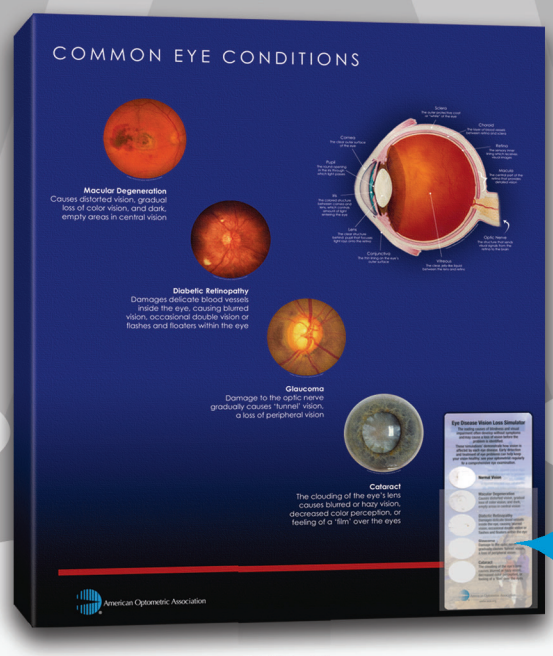

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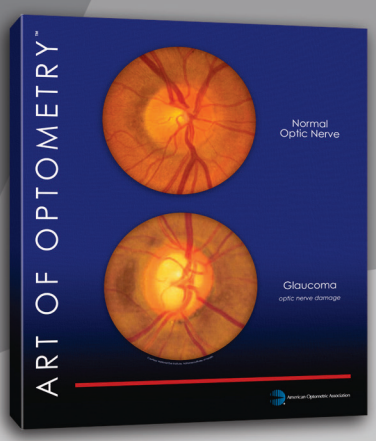
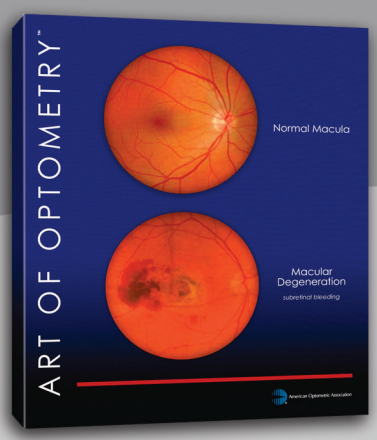
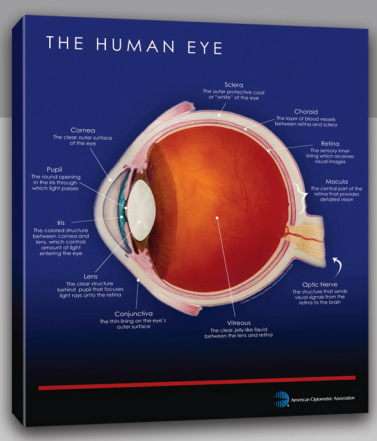


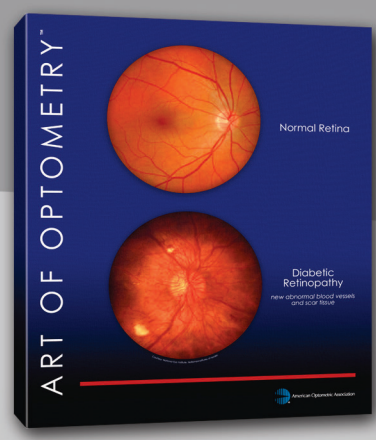
GP-5 *Glaucoma*



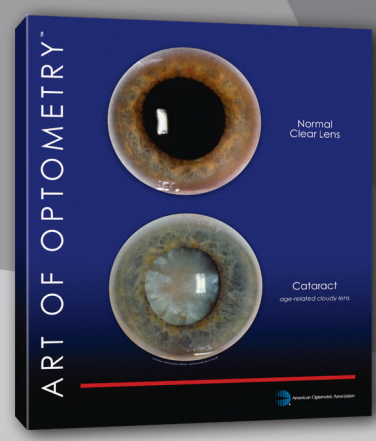
GP-6 *Macular Degeneration*



GP-9 *The Human Eye*



GP-7 *Diabetic Retinopathy*



GP-8 *Cataract*

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New online system may help ODs spot Marfan syndrome

Results of a recent survey underscore the potentially important role that optometrists could play in the diagnosis of Marfan syndrome, according to the National Marfan Foundation (NMF).

Marfan syndrome (also called Marfan's syndrome) is a potentially fatal, genetic, connective tissue disorder. Most of the readily visible signs of Marfan syndrome are associated with the skeletal system.

Many individuals with the condition grow to above-average height. Some have long, slender limbs (dolichostenomelia) with long fingers and toes (arachnodactyly).

However, life-threatening aortic tears and ruptures are the most serious aspect of the disease, the foundation emphasized.

Marfan syndrome can also produce skeletal anomalies such as abnormal curvature of the spine (scoliosis), as well as pain in the joints, bones and muscles in some patients.

Eye conditions, including myopia, amblyopia, strabismus, glaucoma and retinal detachments are often early signs of Marfan syndrome.

One-third of Marfan patients in a recent NMF survey said a dislocated lens in the eye was the first sign to raise suspicion that they might have the life-threatening health condition.

> *"Early diagnosis is critical so that patients can take medications to lower their heart rate and blood pressure, make lifestyle adaptations (no competitive or contact sports), and have their aorta monitored so they can have surgery before a potentially fatal tear or rupture."*

However, only about 20 percent of respondents indicated an ophthalmologist (15 percent) or optometrist (4 percent) was the first person to suspect they might have Marfan syndrome.

Because early diagnosis and treatment are critical to preventing the life-threatening aortic tears and ruptures associated with Marfan syndrome, the NMF is urging optometrists to become more aware of Marfan symptoms and know when to refer patients to a specialist for the specific tests that are required for a diagnosis.

"Early diagnosis is critical so that patients can take medications to lower their heart rate and blood pressure, make lifestyle adaptations (no competitive or contact sports), and have their aorta monitored so they can have surgery before a potentially fatal tear or rupture," said Irene Maumenee, M.D., a member of the NMF Professional Advisory Board and director of ophthalmic genetics at the University of Illinois Eye and Ear Infirmary.

Because Marfan syndrome can seriously affect the eyes and vision, patients with the disease are likely to seek an eye examination, the NMF emphasized.

Myopia – particularly severe myopia – and astigmatism are common among Marfan patients. A dislocating lens will round off and induce myopia. Myopia can also be the result of increased length of the eye. Once the lens is totally dislocated, it will drop into the vitreous and its absence in the visual axis will induce hyperopia.

Subluxation of the crystalline lens in one or both eyes is progressive and may occur in as many as 80 percent of Marfan patients.

With Marfan syndrome, early dislocation occurs commonly in a superotemporal direction, whereas in the similar condition, homocystinuria, the dislocation is often towards inferonasal.

Early onset glaucoma is also common among Marfan patients.

In some Marfan patients, a detachment of the retina may occur prior to lens dislocation or glaucoma.

In patients with a family history of Marfan syndrome or classic symptoms of the disease, such eye problems "should raise a red flag," Dr. Maumenee said.

Potential Marfan patients should be referred immediately to a patient's primary medical doctor or to a cardiologist for additional testing, including a recently developed genetic test for the condition, Dr. Maumenee said.

To help optometrists and other health care practitioners identify Marfan patients, the NMF has developed a mobile website, *MarfanDX.org*, that features the Ghent Nosology for Marfan Syndrome.

The new nosology, published in 2010 by an international panel of experts in the diagnosis and management of Marfan syndrome, offers seven simple formulas for diagnosing Marfan syndrome.

These formulas, along with an Interactive Systemic Score Calculator used to consider the lesser characteristics of Marfan syndrome throughout the body, such as facial features, manifestations in the arms and wrists, and severe myopia, and a Z-score calculator, are available to practitioners on *www.MarfanDX.org*.

The mobile website offers practitioners an interactive online scorecard, complete with illustrations and details on each on manifestation.

The online system will compute the patient's Marfan Systemic Score and even provide a means to e-mail the results to a specialist.

"This site guides the practitioner through the diagnostic sequences needed to accurately identify the patient with Marfan's. Optometrists can utilize this tool to re-familiarize themselves with Marfan's syndrome and reaffirm their readiness to diagnose and provide care for patients with the condition as part of an integrated health care team," said AOA Health Promotions Committee Chair Robert P. Bittel Jr., O.D.

Both the Ghent Nosology for Marfan Syndrome and Marfan Systemic Score system can now be accessed on the foundation's new Marfan Diagnosis website (*www.MarfanDX.org*).

CMS: Medicare prepayment review demonstration to begin in August

The Centers for Medicare & Medicaid Services (CMS) plans to launch its Recovery Audit Prepayment Review Demonstration on Aug. 27, according to a notice at *www.cms.gov*.

The Recovery Audit Prepayment Review Demonstration will target institutional claims. However, the program demonstrates the CMS is moving quickly toward prepayment claim reviews and health care practitioners could increasingly be subject to such audits in the future, said the AOA Advocacy Group.

The three-year demonstration, announced last November, will audit medical records for claims after the claims are submitted but before they are paid. As with other medical necessity audits, the outcome for this demo will be based on the reviewer's clinical judgment about whether an item or service was eligible for Medicare coverage and was medically reasonable and necessary, according to the CMS.

"These reviews will focus on seven states with high populations of fraud- and error-prone providers (Florida, California, Michigan, Texas, New York, Louisiana, Illinois) and four states with high claims volumes of short inpatient hospital stays (Pennsylvania, Ohio, North Carolina, Missouri) for a total of 11 states," the CMS said. "A special Open Door Forum will be held in August to discuss this demonstration and details will be posted... when available."

The project's original Jan. 1 start date was delayed, as advocated by the American Hospital Association.

Salus names Mittelman as new president of university

Salus University Board of Trustees Chair Jo Surpin announced Rear Adm. Michael H. Mittelman, O.D., MPH, will succeed Thomas L. Lewis, O.D, Ph.D., as the university's next president.

Dr. Mittelman is the recipient of the AOA 2012 Distinguished Service Award.

"With 32 years as a senior health care executive in the U.S. Navy, Dr. Mittelman brings a wealth of experience to the position of president that includes clinical and research backgrounds," Surpin said. "Along with his extensive knowledge of multiple health care disciplines and health care delivery to diverse populations, Dr. Mittelman has worked closely with all of the health care professions, focusing on the provision of quality care for the whole patient. I am certain that under Dr. Mittelman's leadership Salus will continue to prosper and become the nation's leading provider of high quality health care professionals – which is very much in keeping with the Salus mission and credo."

An active-duty member of the Armed Forces, Dr. Mittelman will complete his service with the Navy before beginning as Salus University president sometime in late spring or early summer 2013.

In order to accommodate this timing and to ensure a smooth transition, Dr. Lewis has agreed to remain as president during this period as president-designate,

Currently serving as Deputy Surgeon General of the Navy and Deputy Chief, Bureau of Medicine and Surgery, Dr. Mittelman's naval service has included a variety of positions around the world:

- Staff optometrist and later, head of the Optometry Department, Naval Hospital Cherry Point, Marine Corps Air Station Cherry Point, N.C.
- Head of the Optometry Department, U.S. Naval Hospital, Rota, Spain
- Head of the Optometry Department, Naval Aerospace Medical Institute, Pensacola, Fla.
- Deputy Director of Research, Naval Aerospace Medical Research Laboratory, Pensacola, Fla.
- Head of the Recruit Medicine Department and Commanding Officer of Fleet Hospital Three, Naval Hospital, Great Lakes, Ill.
- Command, Naval Ophthalmic Support and Training Activity, Yorktown, Va.
- Command, U.S. Naval Hospital Okinawa, Japan
- Executive Assistant to the Surgeon General of the Navy
- Special Assistant to the Surgeon General at Headquarters, U.S. Marine Corps
- Deputy Chief of Staff, Human Resources, Bureau of Medicine and Surgery
- Director, Medical Resources, Plans and Policy Division (N931), Office of the Chief of Naval Operations
- Director of the Medical Service Corps
- Command Surgeon, U.S. Joint Forces Command and Medical Advisor to the Commander, Supreme Allied Command for Transformation (NATO)
- Command Surgeon, U.S. Pacific Command.

A native of Long Beach, N.Y., Dr. Mittelman earned a Bachelor of Arts degree from Jacksonville University in 1975. After earning his Doctor of Optometry degree from the Pennsylvania College of Optometry (now Salus) in May 1980, he was commissioned into the Navy Medical Service Corps. In 1990, he earned a Master of Public Health degree from the University of Alabama at Birmingham and graduated from the Naval War College non-resident program in 1991.

Dr. Mittelman is a Fellow of the American College of Healthcare Executives. He is a Fellow of the American Academy of Optometry and a diplomate in its section in Public Health and Environmental Vision. He is past president of the Armed Forces Optometric Society and recipient of its Orion Award.

Dr. Mittelman and his wife, Tanis, reside in the Washington, D.C., area and have three daughters.

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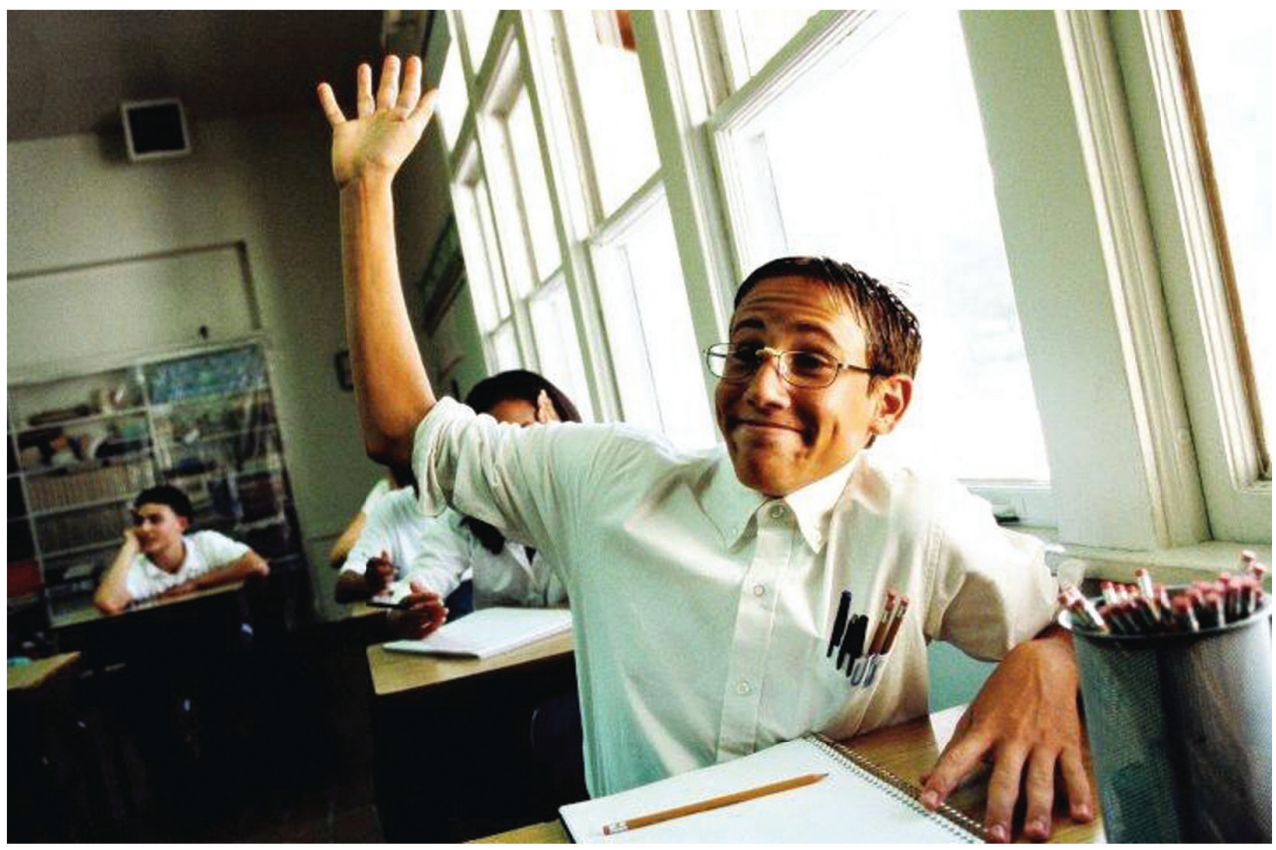

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EyeLearn™ course spotlight

SUN Prescribe CE course is 'call to action'

The AOA EyeLearn™ optometric education portal's new "SUN Education Series Part 2 — Prescribe" course is more than just an opportunity for optometrists to earn continuing education credits online, it's a "call to action," according to instructor John Lahr, O.D.

Introduced last month, the "SUN Prescribe" course was developed by the AOA and the Opticians Association of America (OAA), with support from Luxottica and The Vision Council, as part of their joint SUN Initiative to avert a predicted upsurge in sight-robbing by ultraviolet (UV)- and high-energy visible light (HEV)- related eye conditions by encouraging the use of protective outdoor eyewear.

The "SUN Prescribe" course outlines an "action plan" for participation by optometrists and practice staff in the SUN Initiative, said Dr. Lahr.

The EyeLearn™ "SUN Part 1 – Protect" course, introduced in May, explains why public health officials anticipate epidemic levels of UV- and HEV-related eye conditions – such as age-related macular degeneration (AMD) and cataract – over the coming years, but are also convinced that such eye problems could be virtually eliminated as major public health risks through increased use of protective outdoor eyewear.

The EyeLearn™ "SUN Part 3 – Present" course, slated for introduction later this year, will offer practitioners practical tips on making that eyewear available to patients.

However, the "SUN Prescribe" course focuses on perhaps the key aspect of the SUN Initiative: actively prescribing, not simply recommending, UV- and HEV-protective eyewear to patients, Dr. Lahr said.

The course outlines:

- The reasons for prescribing, rather than just advising patients on, UV- and HEV-protective eyewear
- Goals and metrics to determine if the prescribing of sun-protective eyewear is effective
- Rules for defining the unique UV and HEV protection needs of patients and then prescribing the most appropriate protective eyewear solutions, and
- Examples of "questions and answers" that can be effective in explaining the importance of proper UV and HEV protection to various types of patients.

"The course really calls on practitioners and staff to adopt a new mindset in which emphasis is placed on ensuring protection against UV- and HEV-related eye conditions."

"The course really calls on practitioners and staff to adopt a new mindset in which emphasis is placed on ensuring protection against UV- and HEV-related eye conditions," Dr. Lahr observed.

All SUN Education Series courses are COPE-approved for continuing education credit.

The SUN Education Series, like all AOA EyeLearn™ courses, is available free of charge to AOA members.

Certificates will be issued to those who successfully complete all three of the series modules.

AOA members can access the EyeLearn™ education portal at *www.aoa.org/eyelearn*.

Check out EyeLearn today at www.aoa.org/eyelearn

ICO announces new vision and aging center, appointment of president as medical adviser

The Illinois College of Optometry (ICO) announced the founding of the Alfred and Sarah Rosenbloom Center on Vision and Aging, a new facility devoted to the vision care needs of the aging population.

The center, located within the Illinois Eye Institute on the ICO campus, will ultimately have four essential functions: to promote optometry students' and practitioners' increased knowledge and understanding of the interrelatedness of aging and vision care; to provide vision care, counseling and support services for older adults and underserved communities in and around Chicago; to develop ongoing relationships with selected geriatric care facilities in the Chicago area for education and patient care services; and to sponsor vision-related geriatric research.

The center honors Alfred Rosenbloom, O.D., DOS, and his wife, Sarah. Dr. Rosenbloom served as dean of ICO from 1955 to 1972, president from 1972 to 1982, and remains a distinguished professor emeritus. He was inducted into the National Optometry Hall of Fame in 2010 and continues to be a leader in the optometric profession.

ICO President Arol Augsburger, O.D., said the Rosenbloom Center is an exciting addition to the school.

"To have a prominent ICO alumnus and his wife – and a former president of ICO – make such a significant leadership gift to ICO is transforming for the institution," he said. "ICO will soon be the only optometric institution with a Center on Vision and Aging. This will emphasize and highlight our leadership position in optometry."

ICO also announced the appointment of Dr. Augsburger to the U.S. Department of Veterans Affairs (VA) Special Medical Advisory Group (SMAG). The Under Secretary for Health Robert Petzel, M.D., made the appointment. Dr. Augsburger was nominated for the committee last fall by the Association of Schools and Colleges of Optometry, in consultation with the AOA.

"Dr. Augsburger is joining very elite company," said former ICO president and past director of the VA's Optometry Service Charles Mullen, O.D.

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By John Rumpakis, O.D., M.B.A., President & CEO of ReimbursementPLUS.com

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VA recognizes optometry's essential role in caring for wounded warriors at Walter Reed meeting

AOA President Ron Hopping, O.D., MPH, and Maj. Jeffrey Autrey, O.D., vice president of the Armed Forces Optometric Society (AFOS), visited Walter Reed National Military Medical Center in Bethesda, Md., June 25 to discuss recent advances in caring for wounded warriors with Col. Donald Gagliano, M.D., executive director of the Defense Department/ Veterans Affairs (VA) Department Vision Center of Excellence (VCE).

To help fully coordinate the efforts of the military and veterans' health systems in providing the full range of eye health and vision care to wounded servicemen and women, then-Rep. John Boozman, O.D., (now a U.S. senator from Arkansas) led the successful 2008 effort to establish the VCE to coordinate improved eye health and vision care, assess the prevalence of eye injuries, and track wounded warriors' care and rehabilitation.

Military health officials have estimated that up to 22 percent of all U.S. casualties between 2002 and 2010 have suffered eye injuries or trauma and that upward of 75 percent of service members suffering traumatic brain injury (TBI) have associated vision dysfunction.

Up to 22 percent of all U.S. casualties between 2002 and 2010 have suffered eye injuries or trauma, and upward of 75 percent of service members suffering traumatic brain injury have associated vision dysfunction.

Earlier this year, the VCE moved into its new facility at the nation's flagship military hospital and is preparing a report to Congress. On behalf of hundreds of dedicated military, VA and civilian optometrists involved in wounded warrior care, Dr. Hopping accepted a commemorative VCE "challenge coin" presented by Col. Gagliano.

From left, Executive Director of the Defense Department/ Veterans Affairs Department Vision Center of Excellence Col. Donald Gagliano, M.D., AOA President Ron Hopping, O.D., MPH, and Maj. Jeffrey Autrey, O.D., meet to discuss advances in caring for veterans.

AOA has long history of military, federal service advocacy

For four decades, the AOA has stood alone against organized medicine's repeated efforts to impose limits and assert control over military and federal service optometrists and how they practice, including the vicious and misleading national lobbying and public relations campaign launched in 2009 to smear Veterans Affairs (VA) optometrists and pass legislation expanding the ophthalmology service.

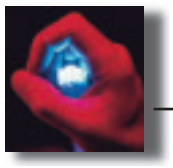
By never hesitating to take on entrenched and misinformed bureaucrats and the armies of medical lobbyists in Washington, D.C., the AOA has expanded opportunities for optometrists in federal agencies and federal programs and gained a seat at the table for optometry whenever and wherever health care policy decisions are made.

In addition, by outworking MDs, their lobbyists and even MD members of Congress on Capitol Hill and in federal agencies, the AOA has led successful efforts to defeat medicine's attacks and derailed anti-optometry bills and proposals.

Moreover, since the 1970s, there have been dozens and dozens of laws enacted that have advanced, expanded and strengthened uniformed and federal service optometry.

Here are some key highlights of the AOA's successful advocacy efforts:

- **2012** After a meeting between Sen. John Boozman, O.D., (R-Ark.) and VA Secretary Shinseki, VA officials inform the AOA that the national program director for optometry will be considered a full-time position permanently.
- **2010-2011** Congress gives priority fast-track approval and the president signs legislation to name the new VA Blind Rehabilitation Center in Long Beach, Calif., for Rob Soltes, O.D., the first military optometrist killed in action.
- **2009-2011** Rear Adm. Michael Mittelman, O.D., appointed as Deputy Surgeon General for the Navy, becoming the highest-ranking optometrist in federal service. Earlier advocacy activity in securing flag rank for an optometry officer assisted in recognition of optometrists as doctors/administrators.
- VA issues revised eye care guidelines reaffirming optometry's status in the VA and setting out a review process assuring full participation by ODs.
- VA officials reject ophthalmology's attacks on VA optometry and directly inform American Academy of Ophthalmology leaders that "ophthalmology will not control optometry in the VA."
- **2007-2009** Establishment of the Department of Defense (DoD)/ VA Vision Center of Excellence
- **2005-2007** Expansion of VA low-vision optometry specialists and VICTORS
- **2003-2004** Congress directs Navy to implement Retention Special Pay for Navy optometrists.
- **2001-2002** Increase in the amount of Retention Special Pay available to optometry officers
- **1999-2000** Extension of provisions of Regular Special Pay, Retention Special Pay and Board-Certified Special Pay for military and Public Health Service (PHS) optometry officers.
- **1997-1998** Authority to repay education loans extended in law to commissioned optometry officers.
- **1995-1996** Retention Special Pay and Board-Certified Special Pay awarded to PHS Commissioned Corps optometry officers. Determination of Constructive Service Credit for Reserve optometry officers.
- **1993-1994** Congress directs expansion in VA Optometry Service.
- **1991-1992** Eye care study supports separate services for optometry. Ophthalmology objects and loses. Congress directs DoD to continue separate services for Army, Navy and Air Force.
- **1989-1990** Separate field services test for Army, Navy and Air Force. Retention Special Pay, Regular Special Pay and Board-Certified Special Pay created for military optometrists (PHS Commissioned Corps not included).
- **1989-1990** Navy Medical Service Corps (Reserve) Flag Rank created by congressional action. Rear Adm. David Sullins, O.D., is the first flag-rank optometrist.
- **1987-1988** Congress instructs Army trial test of administratively separate field services for optometry. Indian Health Services scholarship for optometry. "Eye and vision care" placed in law at the top of the priority list in Title II of the Indian Health Care Amendments legislation.



DIY refractions

Disruptive innovation that affects science, people and the economy

By Dominick M. Maino, O.D., and Geoffrey G. Goodfellow, O.D.

Are refracting opticians the only potential threat to the delivery of optometric refractive care? Probably not. New technology like the NETRA device may also become significant in how refractive care is delivered to our patients.

I (Dr. Maino) met Vitor Pamplona at an American Academy of Optometry meeting where his poster was just down the way from mine. We chatted a bit, and then I tried a self-refraction using the NETRA device connected to a cell phone. Did it work for me? I'll discuss that a bit later.

In a recent phone interview (and while reviewing his website) I learned that Dr. Pamplona finished his Ph.D. in computer science. He is also the chief technology officer for EyeNetra Inc. and is currently working on the next generation of NETRA (NETRA-G) (*http://eyenetra.com*).

He and his team are also developing a new health care app called Test2Connect. This is a new cloud-based system that connects patients and providers of services and products through a mobile app.

His website states that 2.4 billion people worldwide who need glasses do not have them due to a lack of available eye and vision care.

Even though eyeglasses can cost as little as $0.75 a pair, there are no cost-effective, high-quality, or remote refractive tools available to meet the demand.

According to Dr. Pamplona, current diagnostic tools are expensive, bulky, require significant training, and do not allow for data digitization or access to appropriate products/services from remote locations.

Should this be considered a disruptive innovation that affects science, our patients and the economy?

There is little doubt that this technology can be a significant game-changer within the health care arena!

Can you image your patients going into a mall, downloading the refractive app, renting the NETRA device, connecting it to their cell phone and generating their own prescription at little to no cost!

They could then go over to the nearby optical shop that has a 3-D scanner that takes precise facial measurements.

In few minutes, they would then pick up their new glasses that were just made by the shop's 3-D printer (more about 3-D printers in another column).

During our phone conversation, Dr. Pamplona predicted that eventually this device (3-D printers) would not only be available at the mall but in patients' homes as well.

Don't panic just yet. Well maybe you should, just a little.

Dr. Pamplona told me that one possible business model would be based on Netflix. You would order a pair of lenses in several different frames, keep the ones you want, and return the rest!

He believes ophthalmologists do not want to do refractive care, but this could help them provide this patient service.

He noted the average optometrist could be at financial risk because of NETRA.

However, the optometrist could use this the same way an auto-refractor is currently being used in the office. In this scenario it would be under the doctor's domain at all times.

The optometrist could use this the same way an auto-refractor is currently being used in the office. In this scenario it would be under the doctor's domain at all times.

So far, NETRA has only studied its use with its targeted audience of normal adults 22 to 60 years old.

Once appropriate protocols are established (more than likely in a game-like format), testing with children may begin.

NETRA has not been used with patients with special needs, amblyopes/strabismics or the geriatric population.

The newer model is a binocular version that takes into consideration the patient's accommodation and vergence demands.

None of these devices is currently commercially available.

The researchers and business people at EyeNetra do not have a game plan to win over eye care professionals to this device since this technology (and time) will make the decision for the health care professionals involved.

Dominick Maino, O.D., samples the NETRA smartphone device.

They believe this will allow doctors to become patient advisers and teachers and not "data collectors."

Dr. Pamplona even believes that within the next five years or so an optical coherence tomography-like device will be available within the home that will easily monitor optic nerve changes over time.

He suggests that similar medical devices will be used within the home with the end result being decreased visits to the physician's office and laboratory.

Are you ready for the logical outcomes of devices like this? I predict what will happen is that after all the easy 2.00 D myopes are given their glasses, the hundreds of thousands of patients who need the doctor and not just the technology will make refractive care a true non-surgical specialty.

As you know, this speciality is one in which we as optometrists already excel.

This will allow us to be able to charge for not only the science involved in refractive care, but also for the art at an appropriate fiscal level.

By the way, since I have an Array Multifocal intraocular lens, NETRA did not accurately determine my refraction.

The future is still bright!

Dr. Maino is a professor of pediatrics and binocluar vision at the Illinois College of Optometry (ICO) and a recipient of the Leonardo da Vinci Award of Excellence in Medicine. He can be contacted at dmaino@ico.edu. *Dr. Goodfellow is an associate professor of optometry at ICO and the college's assistant dean for curriculum and assessment. He can be contacted at* ggoodfel@ico.edu.

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GP-9 –
The Human Eye

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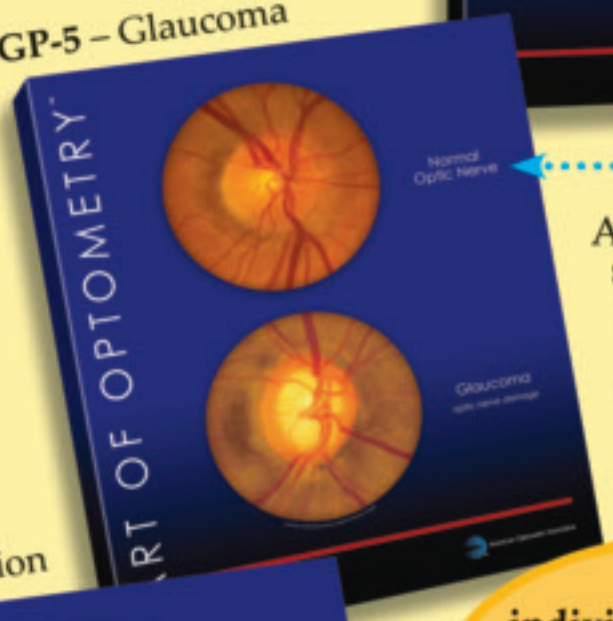
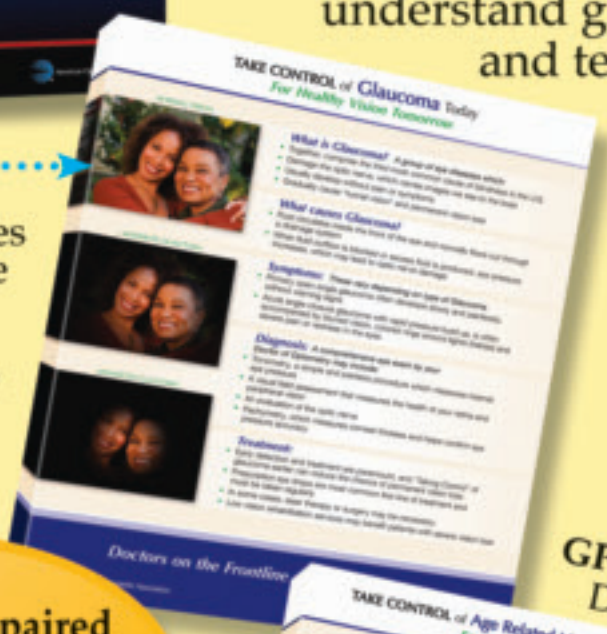
GP-5 – Glaucoma

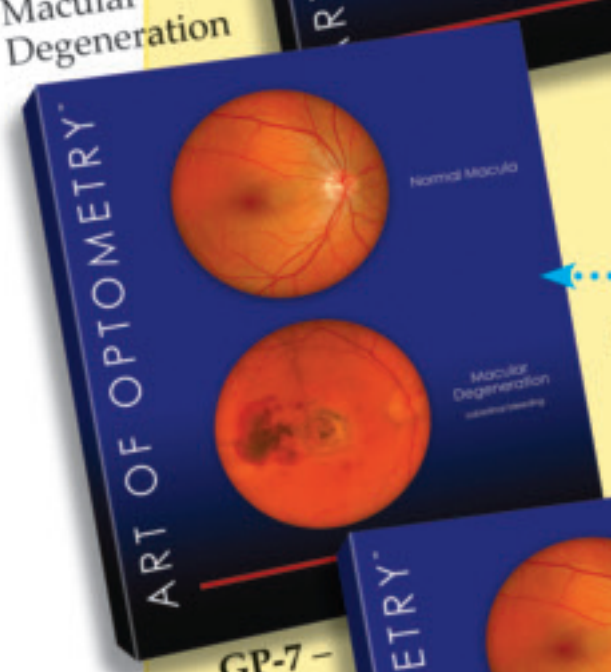




GP-1 –
Glaucoma

All canvases shown are 20"x 24"; NO *additional framing required.*

GP-6 –
Macular Degeneration

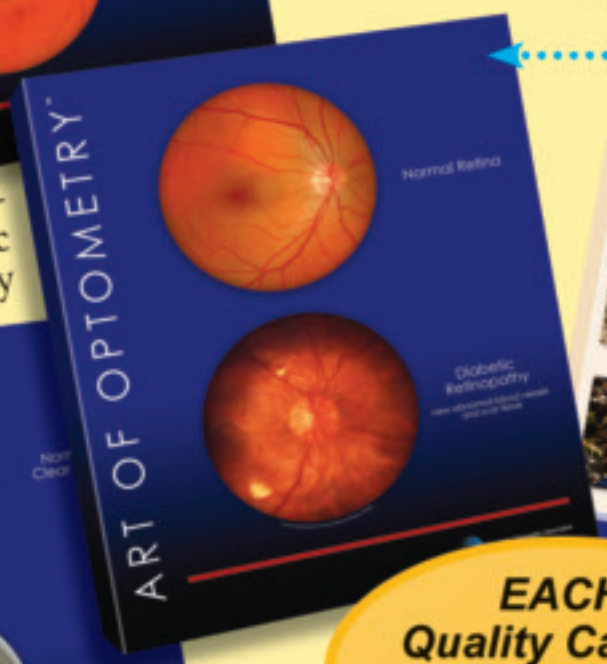


Display individually *or* paired with each corresponding canvas *($178 Per Pair)*

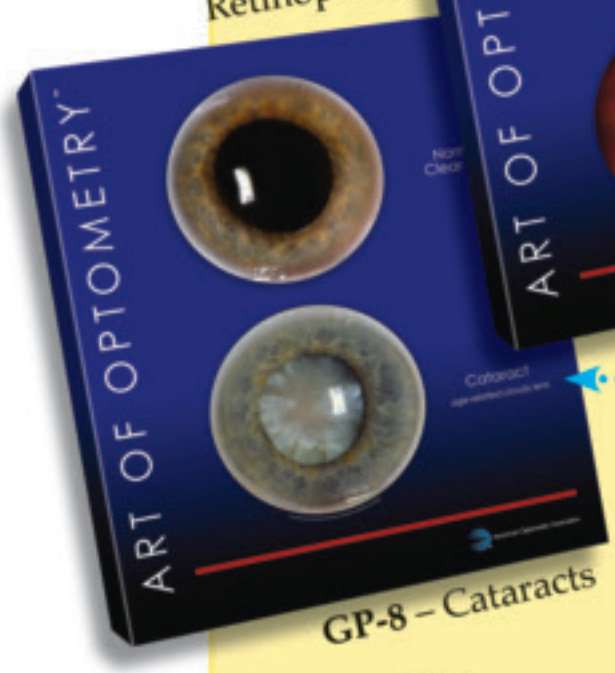
GP-2 – Macular Degeneration

Ready to hang *(hardware included)* in your exam room or lobby

GP-7 –
Diabetic Retinopathy



GP-3 –
Diabetic Retinopathy



GP-8 – Cataracts

EACH Quality Canvas $89

GP-4 – Cataracts

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Check out Practice Strategies, a popular section of Optometry, now in the AOA News, with expanded content and timely resources.

Optometric Economics

HHS-OIG: Medicare E&M costs increasing

Medicare Part B costs for evaluation and management (E&M) services are rising more rapidly than other Part B costs, according to a report issued last month by the U.S. Department of Health & Human Services' Office of the Inspector General (HHS-OIG).

"Between 2001 and 2010, Medicare payments for Part B goods and services increased by 43 percent, from $77 billion to $110 billion. During this same time, Medicare payments for evaluation and management (E/M) services increased by 48 percent, from $22.7 billion to $33.5 billion," the HHS Inspector General noted.

The report shows that use of higher-level E&M codes is increasing, compared with lower-level E&M codes.

"E&M services have been vulnerable to fraud and abuse," the report added. A U.S. Centers for Medicare & Medicaid Services (CMS) study found that certain types of E/M services had the most improper payments of all Medicare Part B services.

However, the report does not establish that the increased use of higher level E&M codes is the result of improper claims, the AOA Advocacy Group noted.

Much of the increase in E&M code use over the past decade is attributable to care provided in hospitals or emergency rooms, according to the HHS Inspector General.

However, the report also finds physicians have increased their billing of higher-level E&M codes for all types of patient visits.

The report suggests optometrists use E&M codes less often than some other health care professionals.

Because E&M codes are used to report complete physician-patient encounters, which are relatively less expensive than individual procedures billed separately, and patient management can help avoid unnecessary procedures, particularly in facilities, proper use of E&M codes could actually help to slow overall cost increases in Medicare, the AOA Advocacy Group noted.

"As with all coding, it is critical that all physicians, including optometrists, continue to provide the care each patient needs, keep an excellent record of all that is done, and choose all codes based purely upon the content of the record and the CPT definitions for the services," said Charles B. Brownlow, O.D., AOA coding consultant.

The HHS Inspector General has identified approximately 1,700 physicians who consistently billed higher-level E&M codes in 2010, according to the report.

The majority of physicians found to be billing with the highest-level E&M codes specialize in internal medicine, family practice, and emergency medicine, according to the HHS Inspector General.

Together, those professions represent more than 40 percent of the top E&M code billers, according to the report (see chart).

Ophthalmologists represent 3.2 percent of the practitioners who consistently use higher-level E&M codes to bill Medicare.

Optometrists account for only 2.2 percent of the practitioners who consistently use higher-level E&M codes, according to the HHS Inspector General.

Last month's report is the first in a series of planned HHS Inspector General evaluations of E&M services.

Subsequent evaluations will determine the appropriateness of Medicare payments for E&M services and the extent of documentation vulnerabilities in E&M services.

The CMS has formally concurred with HHS-OIG recommendations, included in last month's report, to continue physicians' education on proper billing for E&M services and encourage Medicare payment contractors to review physicians' billing for E&M services.

The CMS "partially concurred" with a third recommendation to review physicians who bill higher-level E&M codes for appropriate action, according to the report.

AOA members can review Medicare guidance on the use of E&M codes on the AOA's Coding Today website (*http://aoacodingtoday.com*) and also access webinars and other materials related to accurate coding at *www.aoa.org/archivedwebinars* and *www.aoa.org/coding*.

The complete HHS Inspector General's report, "Coding Trends of Medicare Evaluation and Management Services" (OEI-04-10-00180), can be accessed online at *http://go.usa.gov/Vyt*.

The report suggests optometrists use E&M codes less often than some other health care professionals.

Percentage of high-level E&M code users

Specialty	Health care professionals, by specialty, as percentage of professionals found to consistently bill higher-level E&/M codes	Health care professionals, by specialty, as a percentage of professionals found to bill with lower-level E&M codes or CPT procedure codes
Internal Medicine	19.8%	18.1%
Family Practice	12.2%	14.7%
Emergency Medicine	9.9%	7.1%
Nurse Practitioner	4.4%	5.2%
Obstetrics and Gynecology	4.3%	1.9%
Cardiovascular Disease, Cardiology	4.0%	4.7%
Orthopedic Surgery	3.9%	4.1%
Psychiatry	3.8%	1.8%
General Surgery	3.2%	3.5%
Ophthalmology	3.2%	2.3%
Anesthesiology	2.6%	0.6%
Physician Assistant	2.3%	4.0%
Optometry	**2.2%**	**1.8%**
Otolaryngology	2.2%	1.7%
Neurology	2.0%	2.3%
Gastroenterology	1.9%	2.4%
General Practice	1.4%	1.4%
Pulmonary Disease	1.3%	1.8%
Physical Medicine and Rehabilitation	1.2%	1.4%
Urology	1.2%	1.9%
Endocrinology	1.1%	0.9%
Nephrology	1.1%	1.5%
Podiatry	1.1%	2.9%
Other specialties	14.0%	11.0%

Take the good with the bad: Staff reviews that enhance future performance

Once a year there comes a time that brings back childhood memories and uneasy feelings associated with getting a report card or attending a parent-teacher conference: the employee performance review.

Performance reviews should not only be about finding areas that need improvement but they should also focus on the performance goals the employee has successfully met.

According to an *About.com* article, "How to Do an Employee Appraisal," the goal of the performance review should be to "increase communication, establish clear expectations, reinforce good performance, improve unsatisfactory performance, and foster a spirit of cooperation and teamwork."

One key factor that should not be understated is for supervisors to provide positive feedback in the performance review that reinforces and rewards their employee's hard work. It is important to realize that positive feedback is the sugar that helps the medicine of constructive criticism go down easier.

Back to the basics

Long before the performance review takes place, specific standards and goals should be set for the employee that are based on job responsibilities. These goals should be specific, measurable, written and clearly communicated.

By setting specific goals, the employee can be judged on performance and the results they have achieved in reaching their goals.

Communicating expectations and providing written goals may eliminate misunderstandings and quantify specifically what is expected of the employee. Written goals should be kept in a place visible throughout the year so the employee may refer to the goals on a regular basis. They will be out of sight and out of mind if tucked away in a folder somewhere in the office.

A well-managed review process provides time to discuss employee development that will enhance future performance, as well as time to develop a closer relationship between management and staff, and may provide protection from a wrongful discrimination lawsuit.

Long before the performance review takes place, specific standards and goals should be set for the employee that are based on job responsibilities. These goals should be specific, measurable, written and clearly communicated.

Setting the stage for a successful review experience

1. Provide continual coaching and feedback throughout the year concerning any performance problems or behavior issues so there are no "surprises" on the day of the review.
2. Meet in a neutral location rather than the supervisor's office. This will help relieve stress and will put the employee at ease.
3. Make sure the review is conducted in a location that others will not interrupt or overhear the conversation. If there is not another option besides the supervisor's office, it is recommended to at least come from behind the desk and sit next to the employee.
4. Schedule ample time for the discussion. Forward the phone to voice mail and focus all attention on the task at hand.
5. Begin the review with some positive feedback and encouragement.
6. Because most people internalize only one or two points after a conversation or meeting, think about the one or two points on which you want the employee to focus.
7. Give the employee a chance to talk and explain the challenges they are dealing with. It is much easier for the employee to accept criticism if they feel understood. Make sure the employee feels his or her challenges have been acknowledged and management hears them.
8. Appropriately document the review. If there are performance standards that are not being met, it is vital that those issues be documented in the review as a valuable tool to protect the practice from a wrongful discrimination lawsuit later.

Preparing for the review: employee

If the office requires employees to fill out self-assessments, submit the form at least two weeks prior to the review. Gather specific facts and figures about the goals achieved throughout the year. It can be hard to remember everything that has been accomplished over the last several months, so keeping a journal or file on a weekly basis may help when filling out the self-assessment at year's end.

By inserting the dates, names, contributions, achievements and intangible factors in the weekly file, it will eliminate having to go back and find the information at a later date. Include in the file any documentation from the performance period, including patient comments, notes, and letters of commendation.

Ask questions regarding where improvements have been made, what were major achievements, and what areas need improvement.

Identify some of the personal and professional goals you would like to accomplish in the upcoming year. Make a list ahead of time so they may be discussed with the supervisor during the review.

While making the list of goals, write down any training or materials that may be needed in order to accomplish those goals. What are the tools that would help make the job more effective and staff time more productive?

Preparing for the review: employer

Management can build from the past by taking time to go over the employee's job description. Take time to write down the areas of excellence and note specific examples to share with the employee. If there are areas for improvement, make sure to develop specific suggestions to discuss with the employee how to enhance their performance in the future.

The employee will be anxious during the review, so having a list of questions to engage the employee in the discussion will help put them at ease. Questions could include:

- What is the most enjoyable aspect of the job? The least?
- Are there any barriers that inhibit your performance of the job responsibilities?
- What are the areas of need you have identified for future training or new responsibilities of interest?
- What changes could be made to improve overall job satisfaction?

Building for the future

No matter if it is called a performance review, employee appraisal or performance evaluation, the overall function is to evaluate job performance. Reviews often determine raises, promotions, and sometimes whether a job is kept or termination is near.

Ultimately, regard the review as a learning opportunity. It is a time for the supervisor to talk with the employee about enhancing performance and development, not a session for just finding fault. If the performance review is done well, it provides a huge return on investment for the management team's time.

Further information is available at *http://careerplanning.about.com/od/performancereview/a/reviews.htm*.

Join the discussion!
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Simply log in with your member number (or email address) and password (your six-digit birthdate) and click on Communities.

Chill out: How to recognize the signs and symptoms of excessive occupational stress

By Darlene Leuschke and Sharon Alderson, Commission on Paraoptometric Certification

Picture this. It is back-to-school time and the office is packed. Children may be running amok in the office while others are crying. You are in the process of implementing electronic health records (EHRs) in the office, there are two emergency patients that must be seen and a co-worker has called in sick. Can you say STRESS?

It seems these days that everyone is stressed about something at home or at work and often in both places.

Workers in the health care industry are no exception. With the implementation of new methods of record-keeping, coding and billing standards, and new regulations, it's nearly impossible to avoid workplace stress.

Economic conditions over the past several years have also contributed greatly to workplace stress for many Americans as budget cuts and layoffs result in more demands being placed on the remaining staff. Fear and uncertainty about the future contribute to even higher levels of stress.

How is stress defined and why is it so bad? Stress is a biological or psychological reaction in your body to a perceived threat or aggression. This reaction is commonly known as the "fight or flight reaction" – a natural alarm that goes off in your body and results in an immediate and brief hormonal response.

When a threat or aggression is perceived, the adrenal gland releases a surge of hormones including adrenaline and cortisol into the bloodstream. Adrenaline increases the heart rate and energy level and elevates blood pressure. Cortisol is the primary stress hormone. It increases blood sugar in the bloodstream and improves the brain's ability to utilize glucose. Cortisol also suppresses the responses and functioning of certain body systems during the perceived threat. Digestive, reproductive, and immune system responses are altered when these hormones are released into the bloodstream.

Once the perceived threat or aggression has passed, your heart rate and blood pressure drop, hormone levels subside, and your body returns to normal. At least that is how the body was designed to function.

However, the typical American is constantly bombarded with situations that we may perceive as threats or aggression.

Consequently, the body reacts more often and maintains the fight or flight reaction longer.

And while not everyone reacts to every situation in the same way, morning traffic, deadlines, increased patient load, financial worries, increased home or family responsibilities, catastrophic events, major life changes, small daily annoyances, all can be causes of stress.

Sustained or chronic stress is linked to many mental and physical problems including depression, anxiety, sleep disorders, memory impairment, cancer, coronary heart disease, digestive problems, obesity, arthritis, and immune deficiencies, to name a few.

Occupational stress has long been recognized as a significant cause of health problems, but what is causing so much stress in the health care workplace?

With the passage of the Accountable Care Act (ACA) and the implementation of EHRs in many health care facilities, the health care industry as a whole has been participating in a huge upheaval and is preparing for an onslaught of new patients as the ACA takes effect.

Estimates are that millions of new patients will be seen by the same or a decreased number of doctors in the United States.

Couple this increase in patient load with doctors and staff trying to learn new EHR systems, while maintaining compliance with HIPAA standards, establishing proof of "meaningful use," decreased reimbursements, stringent enforcement of billing and coding procedures, and the need for more staff, and it's easy to see why stress levels are soaring.

Employers and staff may be frustrated by staff reductions due to the struggling economy and increased responsibilities for the same or less pay.

This may lead to frustration, anger, fatigue, apathy, resentment, and anxiety.

These negative reactions cause stress and impact physical and emotional well-being.

Sustained or chronic stress is linked to many mental and physical problems including depression, anxiety, sleep disorders, memory impairment, cancer, coronary heart disease, digestive problems, obesity, arthritis, and immune deficiencies.

Stress can undermine productivity goals as employees may find it difficult to concentrate on the task at hand, begin to make more mistakes, or start feeling overwhelmed and unable to meet deadlines or expectations. They may become irritable with colleagues or patients.

High levels of stress may also contribute to increased absenteeism and staff turnover.

Learn to recognize the signs and symptoms of excessive stress such as feeling anxious, irritable, or depressed.

Research has linked these negative emotions to heart disease when they are not managed.

Others signs of excessive stress might be loss of interest in work, general fatigue or problems sleeping, problems concentrating, headaches or muscle tension in the neck, shoulders, or back.

People may also display signs of distress outside of work by smoking, consuming too much alcohol, using drugs, and even by withdrawing from social or intimate contact with friends and family.

How stress is dealt with by employers and employees is the key to better overall health and productivity.

Employers can help staff manage stress by encouraging open communication, providing a confidential Employee Assistance Program, allowing frequent breaks during the day, and offering gym memberships as part of the benefits package.

Promote a more relaxed atmosphere by including staff in decisions that may affect their jobs and share information that will reduce anxiety about their future employment.

Hire additional staff if needed to keep the office running smoothly.

The best thing you can do for yourself is learn how to manage your own stress and health.

When you feel at your rope's end, don't go home and do the usual flop on the couch and try to block out the day.

The worst things to combine with stress are suppressing your emotions, overeating, lack of exercise, and smoking. People who suppress feelings of anxiety, anger, or fear have higher incidences of illness.

Release those emotions in a positive way through exercise. Endorphins released during exercise will help decrease cortisol (the stress hormone) levels. If you have a poor diet, make small changes until you achieve a healthier diet.

Drink in moderation and don't use nicotine products. Smoking may seem like it has a calming effect during stress, but in reality nicotine is a stimulant. Smoking may actually increase anxiety and it greatly increases the risk of many types of cancers.

And finally, if the way you are managing stress is not working, change it and try something new. Buy a self-help book, take up a new hobby or sport, look at things from a different perspective, or seek professional help.

As Albert Einstein said, "Insanity is doing the same thing, over and over again, and expecting different results."

Nova researchers defining optometry's role in caring for patients with autism spectrum disorder

Every 20 minutes, a child is diagnosed with autism spectrum disorder (ASD). According to the Centers for Disease Control and Prevention, the prevalence of the condition is one out of 88 children and one out of 55 boys. Given the current prevalence rates, most optometrists can expect to encounter at least one patient with ASD in their day-to-day practice.

The core deficits of ASD include difficulties in communication and social interaction and abnormalities in sensory processing. These deficits challenge the practitioner who aims to examine these patients or address their vision needs. Currently, very little research is available regarding optometric evaluation of patients with ASD.

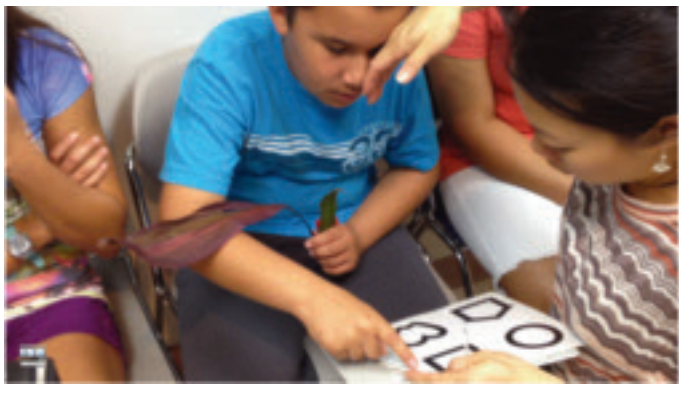
Research under way at Nova Southeastern University (NSU) focuses on answering clinically relevant questions:

- What are expected findings for eye examination in children and adolescents with ASD and how do these compare to those of typically developing kids?
- How can vision testing be modified to enable patients to successfully complete testing?
- Are children and adolescents with ASD more likely to have eye teaming (convergence) problems?
- If patients with ASD have significant refractive error and need spectacle correction, do they adjust to spectacle wear differently than typically developing peers?
- Is there a relationship between optometric test findings and occupational therapy sensory processing measures of vision?

"Good vision is critical for these patients to function and it is important that optometrists bring their expertise to the health care arena."

The studies, led by Rachel A. "Stacey" Coulter, O.D., and Annette Bade, O.D., are multidisciplinary and include pediatric optometrists as well as occupational therapists, and a psychologist with expertise in ASD.

"Autism has been identified as an urgent public health concern. Researchers and health care professionals from all disciplines are striving to meet the demands of caring for these patients and supporting their families," said Dr. Coulter. "Good vision is critical for these patients to function and it is important that optometrists bring their expertise to the health care arena."



Yin Tea, O.D., measures near visual acuity.

Results of these studies, the Convergence in Children and Adolescents Diagnosed with Autism Spectrum Disorder (CICADA) Study and Adaptation to Spectacle Wear Study, will be presented at this year's American Academy of Optometry meeting in a special symposium on Demystifying Vision in Autism. This research will help to define the standard of care for patients with ASD.

In addition to research, the NSU pediatric optometry clinic provides training, for optometric students and residents, in how to evaluate and provide intervention including vision therapy to patients with ASD.

NSU has piloted optometric strategies and content to meet the social and communication difficulties and vision integration challenges that often confront patients with ASD.

"As optometrists and educators, we have a threefold responsibility to teach our students and future optometrists about ASD, to employ scientific research to determine the best practices for patients with ASD and to use evidence-based practices in the optometric care of our patients with ASD. Studies such as those being led by Drs. Coulter and Bade are critical in allowing us to achieve these goals," said Yin Tea, O.D., another Nova researcher.

Disseminating information to practicing optometrists is also a priority.

Faculty member Mary Bartuccio, O.D., is a co-editor of the recently published text "Vision and the Special Needs Patient: Diagnosis and Management" that focuses on optometric care of special needs patients, including those with ASD.

Stanley Tien, an optometrist from Malaysia, visits Nova Southeastern University to learn about vision therapy for patients with autism spectrum disorder from Stacey Coulter, O.D.

Annette Bade, O.D., fits spectacles on a young patient.

Optometrists, such as Stanley Tien, who recently visited the NSU clinic from Malaysia, are able to observe and learn useful clinical techniques.

The research, scholarship and clinical activities of the Pediatric Optometry Service support the work of the Autism Institute, a university-wide group that focuses on collaborative activities in the field of autism spectrum disorders.

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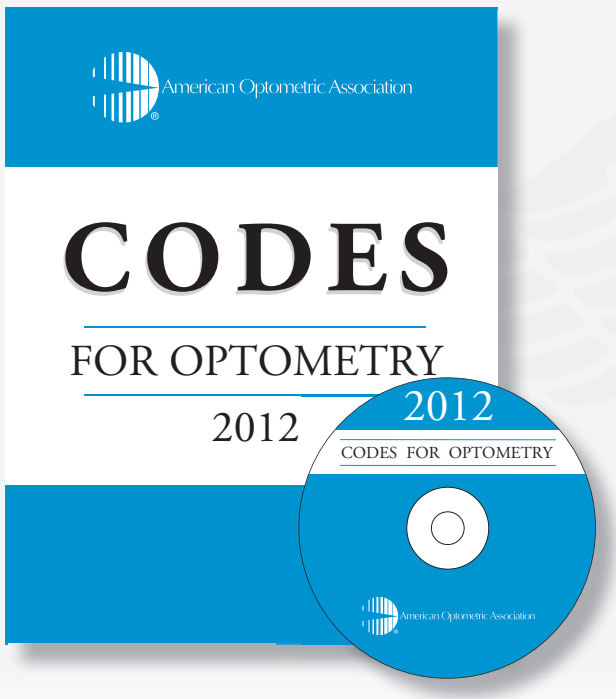

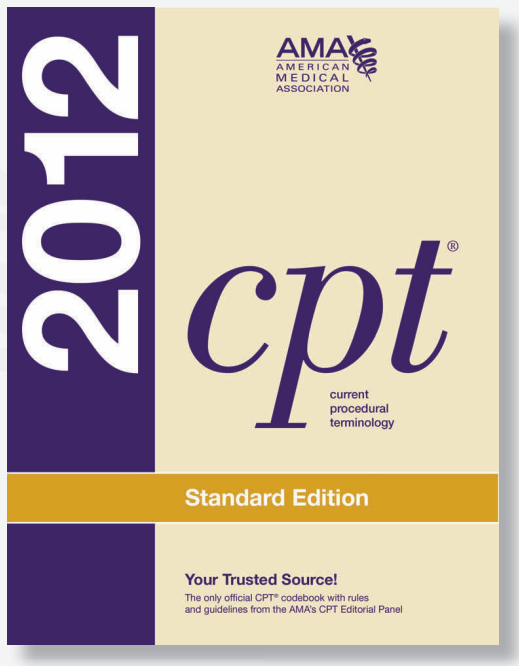

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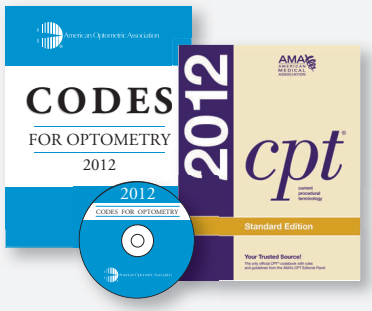

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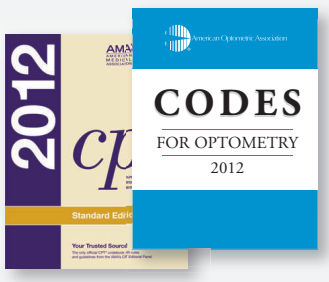

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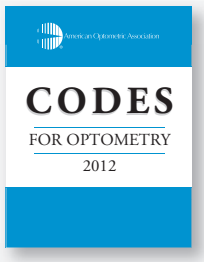

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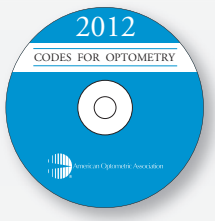

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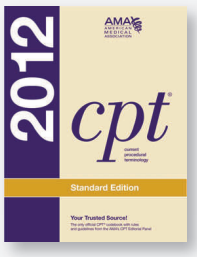

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Industry Profile is a regular feature in AOA News allowing participants of the Ophthalmic Council ™ to express themselves on issues and products they consider important to the members of the AOA.

Industry Profile: Transitions Optical

Transitions Optical: Offering a Family of Products with Authentic Solutions

The ever-expanding, evolving and dynamic family of products available through Transitions Optical, Inc. goes beyond the basic function of a lens to adjust, adapt and enhance vision. While each member of the family brings a unique, innovative vision solution, they are unified by a brand name that empowers eye care professionals with the confidence that their patients' needs will be satisfied.

The Transitions family of brands is divided into two categories.

Transitions® everyday adaptive lenses

Everyday options from Transitions Optical are meant to be worn indoors and outdoors in place of ordinary, clear lenses. They adapt to changing light for more comfortable vision, while protecting the eyes from ultraviolet (UV) radiation. However, each product in this category offers different attributes to provide a range of patient benefits.

- Transitions® VI lenses are the core everyday lenses. These are clear indoors and at night, and darken to provide more comfortable vision in changing lighting conditions outdoors. They are the #1-recommended photochromic lenses worldwide, and are available in all major lens designs and materials.
- Transitions® XTRActive™ lenses are the darkest everyday lenses available. These are designed to have a slight tint indoors and activate behind the windshield of a car.
- Transitions® Vantage™ lenses are the newest addition. They are revolutionary everyday adaptive lenses designed to both darken and increase polarization upon UV exposure to deliver noticeably crisper, sharper vision, even in the brightest outdoor glare.

Transitions® performance sunwear

Transitions performance sun lenses and sunglasses provide wearers a visual advantage during specific outdoor activities by adjusting to changing light conditions for color and contrast enhancement and improved depth perception. Partnering with best-in-class brands, Transitions adaptive sunglasses combine activity-specific color science and adaptive lens technology with frame styles and fit to result in a superior piece of sports equipment.

A full list of these products is available at *www.TransitionsSunwear.com*.

Authenticity Assured

With so many options available, the Transitions Certificate of Authenticity (COA) serves as a clear way to verify that a product is a true Transitions lens. Not only does the COA protect eye care professionals against unauthorized substitution, but it also reassures consumers that they have received authentic Transitions lenses.

Beyond the protection the COA provides, the year's program also enables patients to refer friends to their eye care professionals and gives them access to exciting new prizes – like a $500 instant prize and an Ultimate Sightseeing Dream Vacation. When a patient wins, the dispensing practice gets a $400 Food for Thought Education & Lunch Package.

Additionally, eye care professionals can earn points, which can be redeemed for gift cards and Transitions Optical-branded merchandise. By encouraging patient COA registration, eye care professionals increase their chances to earn prizes, points and patient referrals.

Transitions Optical also donates $1 to a charity supported by the Transitions Healthy Sight for Life™ Fund for each consumer registration.

Eye care professionals can register for the COA program through Transitions Optical Customer Service at 800-848-1506.

At last month's National Urban League conference in New Orleans, optometry students from the University of Houston College of Optometry, University of Alabama at Birmingham College of Optometry and Southern College of Optometry checked for glaucoma and other potential vision problems as part of a program sponsored by Johnson & Johnson Vision Care, Inc., which provided free vision evaluations and patient education to conference attendees.

J&J sponsors vision evaluations at Urban League conference

Johnson & Johnson Vision Care, Inc. sponsored programs for free vision evaluations and patient education to attendees of the National Urban League (NUL) conference at the Ernest N. Morial Convention Center in New Orleans, July 25-28. The conference is a national forum that helps create solutions to the challenges confronting blacks and urban communities.

Vision problems can disproportionately affect certain ethnic groups. For example, glaucoma is the leading cause of blindness in blacks, and half of those with glaucoma don't even know they have it, according to the Glaucoma Research Foundation.

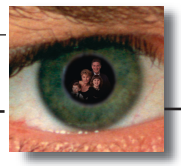
"This is cause for concern because not only are these individuals at greater risk for certain eye conditions and diseases, but research also shows that many are not receiving proper diagnosis and treatment," said Lee Ball, O.D., associate director, Professional Affairs, Vistakon® Division of Johnson & Johnson Vision Care, Inc.

According to a 2006 survey of 676 black Americans, almost all (92 percent) surveyed agreed that maintaining proper vision is an important priority for them, but less than half (47 percent) said they had an eye exam within the past year, while a quarter (24 percent) had not had an eye exam in more than two years. Nearly one-third (30 percent) said their child has never seen an eye care professional.

"Seeing an eye care professional regularly may not only assess vision and the need for updated prescriptions, it may also help identify and lead to a diagnosis of other health concerns such as hypertension and diabetes," added Dr. Ball.

The on-site evaluations, led by local optometrists, consisted of several stations checking for vision, glaucoma and irregularities that may exist in the retina. Following the evaluation, a doctor reviewed the results with each individual and provided educational materials on different eye conditions and the importance of maintaining good vision health.

For more information on the National Urban League, go to *http://nul.org*.



Survey shows parents want high-tech lenses for kids

A recent PPG Industries survey revealed that parents are interested in advanced lens technology and a combination of lens attributes when choosing eyewear for their children and are less price-driven than when choosing eyewear for themselves.

The findings reinforce that multi-benefit lens options like Transitions lenses or Trivex material, which offer clear vision, thinness, light weight, impact resistance and ultraviolet (UV) protection, present a real business opportunity for eye care professionals when making children's eyewear recommendations to parents.

Consider that:

❖ About half (52 percent) of parents felt that a combination of lens attributes (clear vision, thinness, light weight, impact resistance, UV protection) are the most important.

❖ 13 percent said that they would always choose the lens that offers the best vision, while a slightly higher number (15 percent) said price was their primary concern, and 16 percent said impact-resistance, protection and durability was their primary concern.

❖ When choosing for themselves, 21 percent said that price was their main concern.

❖ The majority of respondents (75 percent) agreed that it is important to them that their child's eyeglasses are made with the most advanced lens technology, similar to the responses of parents who were choosing for themselves (71 percent).

75 percent said it's important that their child's eyeglasses are made with the most advanced lens technology

❖ Vision insurance was also a factor in lens material selection, where 86 percent of respondents said it is important to them that their plan covers the most advanced lens technologies for their child's eyeglasses – speaking to the importance of managed vision care plans keeping up with coverage of the latest products.

The online survey was conducted on behalf of PPG Industries from March 1-5, 2012, by Lightspeed among a nationally representative sample of 500 U.S. adults ages 18 and older who wore eyeglasses and had children.

VisionWeb online ordering now available using Safari

VisionWeb announced its online ophthalmic product ordering service is now compatible with Apple Computer's default Web browser Safari.

In the last five years, Apple Computers have quickly become commonplace in many practices, but the default Web browser, Safari, has limited eye care providers' ability to fully reap the benefits of online ophthalmic ordering through VisionWeb.

With this new compatibility, VisionWeb hopes to make convenient online spectacle lens, contact lens, and frame ordering a reality for as many practices as possible – regardless of their technology preferences.

"VisionWeb's ophthalmic product ordering service being compatible with Safari is very exciting news for eye care providers" said Julia Crawford, director of Product Strategy at VisionWeb. "This new compatibility not only means that Mac users will no longer have to download additional software to order products on VisionWeb, but that eye care providers will also have more technology options to choose from when implementing new hardware."

VisionWeb's Safari browser compatibility works for Apple desktops and laptops wanting to use VisionWeb's spectacle lens, contact lens, and frame ordering services, but is not currently available for VisionWeb's electronic claim filing service or Apple iPad and iPhone devices.

VisionWeb's new Safari compatibility also allows Apple computer-using eye care providers to take advantage of their product ordering services full gamut of features, including: 24/7 access to all order and archives, online order tracking, and trace file uploading.

Eye care providers who are not yet VisionWeb members can register for free at *www.visionweb.com*, or by contacting VisionWeb Customer Service at 800-874-6601.

Industry Profile: Optos

Optos plc has the vision to be THE retina company. We aim to be recognized as a leading provider of devices to eye care professionals for improved patient care. Optos' core devices produce ultra-widefield, high-resolution digital images (optomap®) of approximately 82 percent of the retina, something no other device is capable of doing in any one image. Our recent acquisition of OPKO instrumentation brings optical coherence tomography (OCT) diagnostic devices and optical ultrasound scanners, used in the diagnosis and management of eye disease and conditions.

Optos' ultra-widefield retinal imaging technology, combined with the specific data that can be derived from OCT images, has the potential to offer optometrists the most powerful tools for disease diagnosis and management. The optomap images provide enhanced clinical information, which facilitates the early detection and management of disorders and diseases evidenced in the retina such as retinal detachments and tears, diabetic retinopathy and age-related macular degeneration. Retinal imaging can also indicate evidence of non-eye or systemic diseases such as hypertension and certain cancers. OCT delivers an image that shows a three-dimensional, cross-sectional view of the retina in any particular area, typically in the central pole area of the retina around the optic nerve and macula and is used to detect the presence of and understand the severity of disease.

The newest product is Daytona, a tabletop model with new easy-to-use image capture software. Daytona produces optomap ultra-widefield digital retinal imaging procedures to support wellness screening and diagnostic examinations as well as the optomap af ultra-widefield autofluorescence imaging to provide additional clinical data.

Exploring the frontiers and vast potential of retinal medicine, more than 50 papers utilizing Optos retinal imaging technology were presented at the 2012 Association for Research in Vision and Ophthalmology (ARVO) annual meeting in Fort Lauderdale, Fla. These clinical studies represent experience with ultra-widefield imaging in more than 3,000 patients from 10 countries and explore the utility of ultra-wide field and OCT technology in 25 different eye diseases.

Optos' CEO Roy Davis said, "These results underpin our vision to drive our clinical evidence even further. We are now demonstrating to clinicians the ability to see more, refer more, and treat more and importantly to understand more about the extent of eye disease. Further studies are already under way with leading Investigators and with pharmaceutical companies to validate our findings."

A clinical validation study comparing Optos ultra-widefield imaging to Early Treatment Diabetic Retinopathy Study (ETDRS) protocol fundus photography, the gold standard for assessing severity of diabetic retinopathy, was recently completed by the Joslin Diabetes Center and published in the *American Journal of Ophthalmology*.

ETDRS protocol seven standard-field 30-degree color fundus photography has long been the imaging benchmark for assessing diabetic retinopathy severity. This study reports that Optos' ultra-widefield non-dilated optomap images compared favorably with dilated ETDRS photos and dilated retinal examination by a retinal specialist in determining clinical severity of diabetic retinopathy and diabetic macular edema.

For more information about the company or products, visit *optos.com*.

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optometry.nova.edu/ce/index.html

IDAHO OPTOMETRIC PHYSICIANS ANNUAL CONGRESS
Featuring Drs. Paul Karpecki, Charles Brownlow & Nathan Lighthizer
August 23-25, 2012
The Grove Hotel
Boise, ID
Randy L. Andregg, O.D.
208/461-0001
randregg@vision-1.com

SOUTH CAROLINA OPTOMETRIC PHYSICIANS ASSOCIATION
105TH SCOPA ANNUAL MEETING
August 23-26, 2012
Myrtle Beach Marriott Resort & Spa at Grande Dunes
Myrtle Beach, SC
Jackie Rivers/Anna Straub
877/799-6721
info@sceyedoctors.com
www.sceyedoctors.com

UAB SCHOOL OF OPTOMETRY CONTINUING EDUCATION & ALUMNI REUNION WEEKEND
August 24-26, 2012
Hill University Center, UAB Campus, Birmingham, AL
Candie Bratton
205/934-5701
Cbratton@uab.edu
www.uab.edu/optometry

September

UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY ONLINE TEXAS OPTOMETRIC GLAUCOMA CERTIFICATION COURSE
September 5-October 19, 2012
UH College of Optometry
Houston, TX
713/743-1900

MIDDLE ATLANTIC OPTOMETRIC CONGRESS
September 6-9, 2012
Doubletree Hotel and Convention Center, Monroeville, PA
Barry Cohen, O.D.
barryc51@gmail.com

OEP CLINICAL CURRICULUM THE ART & SCIENCE OF OPTOMETRIC CARE-A BEHAVIORAL PERSPECTIVE
September 6-10, 2012
Grand Rapids, MI
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

OPTOMETRIC EXTENSION PROGRAM FOUNDATION
43RD ANNUAL COLORADO VISION TRAINING CONFERENCE
September 7-9, 2012
YMCA of the Rockies
Estes Park, CO
303/683-4466
drjamieanderson@gmail.com
www.visioncare.org

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH SALUS UNIVERSITY
September 7-9, 2012
Elkins Park, PA
402/680-4634
http://salus.edu/alumni/alumni_ce.html

NOVA SOUTHEASTERN UNIVERSITY
FALL CONFERENCE
September 8-9, 2012
Fort Lauderdale, FL
954/262-4224
oceaa@nova.edu
http://optometry.nova.edu/ce/index.html

NORTHEASTERN STATE UNIVERSITY, OKLAHOMA COLLEGE OF OPTOMETRY
FALL PRIMARY EYE CARE UPDATE
September 8-9, 2012
Northeastern State University, Oklahoma College of Optometry, Tahlequah, OK
918/444-4033
Beason01@nsuok.edu
http://optometry.nsuok.edu/ContinuingEducation.aspx

WESTERN UNIVERSITY COLLEGE OF OPTOMETRY
"NEURO-OPTOMETRIC REHABILITATION" CONTINUING EDUCATION SEMINAR
September 8, 2012
Western University College of Optometry, Pomona, CA
909/706-3493
ceoptometry@westernu.edu
http://www.westernu.edu/optometry-continuing-education

NORTHEAST CONGRESS
September 9-10, 2012
Westford, MA
Kathleen Prucnal, O.D.
978/597-5227
drkaprucnal@msn.com

ENVISION CONFERENCE 2012
September 12-15, 2012
Hilton St. Louis at the Ballpark
St. Louis, MO
info@envisionconference.org
www.envisionconference.org

SOUTH DAKOTA OPTOMETRIC SOCIETY
FALL CONFERENCE
September 13-14, 2012
Hilton Garden Inn, Sioux Falls, SD
Deb Mortenson, Exec. Dir.
605/224-8199
Deb.mortenson@pie.midco.net
www.sdeyes.org

CE IN ITALY
September 14-16, 2012
Florence, Italy
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
www.CEinItaly.com

SOUTHWEST COUNCIL OF OPTOMETRY
SWCO MEETING
September 14-16, 2012
InterContinental Hotel, Addison, TX
Niki Bedell, M.P.H.
713/743-1856
FAX: 713/743-6541
www.swco.org

VERMONT OPTOMETRIC ASSOCIATION
ANNUAL MEETING
September 14-16, 2012
Basin Harbor Club, Vergennes, VT
David J. DiMarco, O.D.
802/524-9561
FAX: 802/524-6060
djd@nveyecare.net

CE IN ITALY
September 18-20, 2012
Tuscany Immersion: Castiglion Fiorentino
James L. Fanelli, O.D.
910/452-7225
jamesfanelli@CEinItaly.com
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NEBRASKA OPTOMETRIC ASSOCIATION
FALL CONFERENCE
September 21-23, 2012
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Kearney, NE
noa@AssocOffice.net
Nebraska.aoa.org

UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY
CE IN FORT WORTH
September 22-23, 2012
Alcon Laboratories Schollmaier Auditorium
Fort Worth, TX
713/743-1900
Http://ce.opt.uh.edu/live-events/ceinftw2012

AEA CRUISES OPTOMETRIC SEMINAR
CANADA-NEW ENGLAND
September 22-29, 2012
Aboard the Caribbean Princess
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminars.com

CENTRAL PENNSYLVANIA OPTOMETRIC SOCIETY CE FORUM XVI
Featuring Melton and Thomas
September 23, 2012
The Hotel Hershey
Hershey, PA
Mary Good, O.D.
cposrsvp@gmail.com

AEA CRUISES OPTOMETRIC SEMINAR
VENETIAN INTERLUDE
September 23-30, 2012
Aboard the Ocean Princess
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminars.com

WISCONSIN OPTOMETRIC ASSOCIATION
CONVENTION AND ANNUAL MEETING
September 27-30, 2012
Kalahari Resort, Wisconsin Dells, WI
800/678-5357
joleenwoaoffice@tds.net
www.woa-eyes.org

ILLINOIS OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION
September 28-30, 2012
Crowne Plaza Hotel, Springfield, IL
800/933-7289
www.ioaweb.org

FALL CONFERENCE
KENTUCKY OPTOMETRIC ASSOCIATION
September 28-30, 2012
Embassy Suites Hotel
Lexington, KY
sarah@kyeyes.org

KANSAS OPTOMETRIC ASSOCIATION
FALL EYECARE CONFERENCE
September 28-30, 2012
DoubleTree by Hilton, Wichita, KS
785/232-0225
www.kansasoptometric.org

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH THE TEXAS OPTOMETRIC ASSOCIATION AND UNIVERSITY OF HOUSTON
September 29-30, 2012
University of Houston Campus
Houston, TX
402/680-4634
http://www.ce.opt.uh.edu/live-events/OptoBCertification

NORTH DAKOTA OPTOMETRIC ASSOCIATION
109TH ANNUAL CONGRESS & EXHIBITION
September 30 - October 2, 2012
Ramkota Hotel, Bismarck, ND
701/258-6766
Toll Free 877/637-2026
FAX: 701/258-9005
ndoa@btinet.net
www.ndeyecare.com

October

OHIO OPTOMETRIC ASSOCIATION
EASTWEST EYE CONFERENCE
October 4-7, 2012
Public Auditorium, Cleveland, OH
Linda Fette
800/999-4939
linda@ooa.org
www.eastwesteye.org

SOUTHERN COLLEGE OF OPTOMETRY'S 2012 FALL CONTINUING EDUCATION AND HOMECOMING WEEKEND
October 4-7, 2012
SCO Campus and The Peabody Memphis Hotel, Memphis, TN
Carla O'Brian, 800-238-0180, ext. 5
901/722-3235
ce@sco.edu
www.sco.edu

SOUTHERN COLLEGE OF OPTOMETRY
FALL CONTINUING EDUCATION AND HOMECOMING WEEKEND
October 4-7, 2012
SCO Campus and The Peabody Memphis Hotel, Memphis, TN
Carla O'Brian
800/238-0180, ext. 5
901/722-3235
ce@sco.edu
www.sco.edu

PSS EYECARE
PSS 2012: FORUM ON OCULAR DISEASE
October 6-7, 2012
The Castle Hotel, Orlando, FL
education@psseyecare.com
www.psseyecare.com

For featured calendar events, email t.peppers@elsevier.com.

To submit standard items for the meetings calendar, send a note to eventcalendar@aoa.org.

Please allow several months' lead time.

UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY
WEST TEXAS TWO STEP
October 6-7, 2012
Embassy Suites Hotel
Lubbock, TX
713/743-1900
http://ce.opt.uh.edu/live-events/wtx2012

UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY
CE IN HOUSTON
October 7, 2012
University of Houston College of Optometry Room
Houston, TX
713/743-1900
http://ce.opt.uh.edu/live-events/ceinhouston2012

Michigan Optometric Association
44th Annual Fall Seminar
October 10-11, 2012
Lansing Center, Lansing, MI
Amy Possavino
517/482-0616
FAX: 517/482-1611
amy@themoa.org
www.themoa.org

WISCONSIN OPTOMETRIC ASSOCIATION
NORTHWOODS EDUCATION EVENTS
October 12-13, 2012
Black Bear Lodge, St. Germain, WI
800/678-5357
joleenwoaoffice@tds.net
www.woa-eyes.org

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH THE COLORADO OPTOMETRIC ASSOCIATION
October 12-13, 2012
402/680-4634
http://www.visioncare.org/_programs_information/events.php

HUDSON VALLEY OPTOMETRIC SOCIETY FALL SEMINAR
October 12, 2012
The Grandview
Poughkeepsie, NY
Robert Greenbaum, O.D.
845/473-0220
Robertgreenbaum58@gmail.com
www.hvos.org

VIRGINIA OPTOMETRIC ASSOCIATION
FALL CONFERENCE
October 13-14, 2012
Lansdowne Resort
Leesburg, VA
Bruce Keeney
804/643-0309
www.thevoa.org

IOWA OPTOMETRIC ASSOCIATION
IOWA HAWKEYE INSTITUTE
October 18-19, 2012
Cedar Rapids Marriott
Cedar Rapids, IA
319/393-6600
800/396-2153
www.marriott.com/hotels/travel/cidmc-cedar-rapids-marriott/
or www.marriott.com

Sept. 12-15, 2012
Hilton St. Louis at the Ballpark
St. Louis, MO

info@envisionconference.org
www.envisionconference.org

ABO BOARD CERTIFICATION REVIEW
PARTNERING WITH THE NEW HAMPSHIRE OPTOMETRIC ASSOCIATION
October 19-21, 2012
402/680-4634
http://www.nheyedoctors.biz/2012_weekend.htm

November

OEP CLINICAL CURRICULUM
VT/STRABISMUS & AMBLYOPIA
November 1-4, 2012
Western University College of Optometry, Pomona, CA
Theresa Krejci
800/447-0370
theresakrejcioep@verizon.net

ALABAMA OPTOMETRIC ASSOCIATION
2012 ALOA ANNUAL CONVENTION
November 2-4, 2012
The Wynfrey Hotel
Birmingham, AL
334/273-7895
www.alaopt.com

UNIVERSITY OF HOUSTON COLLEGE OF OPTOMETRY
CE IN AUSTIN
November 3-4, 2012
Omni Austin Hotel Downtown
Austin, TX
713/743-1900
http://ce.opt.uh.edu/live-events/ceinaustin2012

AOA Vision Rehabilitation Section AMD A to Z 2012 course schedule

SOUTH CAROLINA OPTOMETRIC PHYSICIANS ASSOCIATION
105TH SCOPA ANNUAL MEETING
MYRTLE BEACH, S.C.
SPEAKERS: DAWN DECARLO, O.D.
JUSTIN GREEN, PH.D.
AUG. 24-25, 2012
DAY/TIME TBD

NEW JERSEY SOCIETY OF OPTOMETRIC PHYSICIANS
THERAPY BY THE SEA
SHERATON ATLANTIC CITY HOTEL AND CONVENTION CENTER, ATLANTIC CITY, N.J.
SPEAKERS: DAVID LEWERENZ, O.D.
JUSTIN GREEN, PH.D.
SEPT. 22, 2012
10 a.m.– noon

For additional information contact Melissa Flower-*MLFlower@aoa.org*. The schedule and presenters are subject to change.

CLASSIFIEDS

Professional Opportunities

Affordable, Comprehensive, Reliable training for your therapist. Taught by an OD and therapist. The Foundation of Vision Therapy Course, Call OEP 800 447 0370 for information.

Interested in the best systematic approach to Vision Therapy? OEP Clinical Curriculum Courses can help you no matter where you are in your career. Call 800 447 0370.

Gulf Coast Optometry is currently Seeking Full-Time optometrists with diverse practice background to practice in the following locations in Florida: Wesley Chapel, Naples, Cape Coral, Orlando, Daytona Beach, Jacksonville and Ocala. Amazing doctors technicians for support and great staff! Interested candidates should contact Katie DeLeuce @ 239-980-2806

Oldest Eye Practice in Minnesota. The latest technology and equipment. Specialization in eye diseases and Glaucoma. Please send resume to: **dkennedy6648@comcast.net**

Optometrist Wanted- Fort Myers, FL Full and Part-Time Florida licensed Optometrist wanted for a growing 2 location practice next to Lens Crafters. Full scope optometry, with large volume medical optometric care. Cataract, Lasik, Oculoplastics, and Glaucoma post-op care. Large contact lens volume practice. Latest technology including OCT, Retinal Camera, etc. Permanent position available 06/01/2012. Excellent compensation + bonus. If interested forward CV to carlossanchezod@embarqmail.com or call Dr. Sanchez @ 239-560-1571.

Miscellaneous

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Optometrist Wanted- York, PA Full or part-time Fill-in Optometrist wanted for a 3 location private practice. Part-time permanent position potential. Full scope optometry with the latest technology including EHR. Fill-in position available 9/17/2012 through 12/30/2012. If interested, please forward CV to tracey@weavereye.com or call Tracey at (717)741-4788 ext. 1128. For more information on our practice visit www.weavereye.com.

DO YOU WANT TO HELP CHILDREN? 1 out of 4 children struggle with vision problems that interfere with reading and learning. Detection and treatment of these vision problems could be your niche. Learn more about making vision therapy a profitable service in your practice. Call today to schedule a free consultation with Toni Bristol at Expansion Consultants,Inc., specializing in Vision Therapy practice management and marketing since 1988. **Toll free 877/248-3823**.

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Montana Independent Optical Center and Specialty Sunglass Store for Sale; in business 58 years, over 70 brands featured. Space for optometric practice. Near Mountains and the Great outdoors. $56,900 + Inventory, Call Tom Emerling, YBA (broker) at (406) 655-4241.

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VOSH WANTS YOUR USED EQUIPMENT Donate those used ophthalmic instruments that are gathering dust in your storage room for the valuable purpose of training students at Optometry schools in the developing world. VOSH will refurbish this equipment, pay for all shipping to the destination and provide a tax receipt. This program called the Technology Transfer Program (TTP) especially needs trial lens sets and frames, phoropters, projectors, slit lamps, lensometers, keratometers, hand scopes and reference books. Also accepted are unused frames, uncut lenses, optical tools and edgers. Schools that receive equipment become acquainted with the VOSH model. They form new VOSH chapters and treat the disenfranchised within their own country. Its one of our ways of becoming sustainable. Please contact VOSH/International at: www.vosh.org. and help us eliminate preventable blindness.

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Effective the January, 2012 issue onwards, Classified advertising rates are are as follows: 1 column inch = $75 (40 words maximum) 2 column inches -$125 (80 words maximum) 3 column inches = $165 (120 words maximum). This includes the placement of your advertisement in the classified section of the AOA Member Web site for two weeks. An AOA box number charge is $30.00 and includes mailing of responses. The envelope will be forwarded, unopened, to the party who placed the advertisement. Classifieds are not commissionable.All advertising copy must be received by e-mail at t.peppers@elsevier.com attention Tracie Peppers, Classified Advertising. You can also mail the ads to Elsevier, 360 Park Avenue South, 9th floor, New York, NY 10010.

Advertisements may not be placed by telephone. Advertisements must be submitted at least 30 days preceding the publication. All ad placements must be confirmed by the AOA – do not assume your ad is running unless it has been confirmed. Cancellations and/or changes MUST be made prior to the closing date and must be made in writing and confirmed by the AOA. No phone cancellations will be accepted. Advertisements of a "personal" nature are not accepted. The AOA NEWS publishes 18 times per year(one issue only in January, June, July, August, November, and December, all other months, two issues.) and posting on the Web site will coincide with the AOA NEWS publication dates. Call Traci Peppers - Elsevier ad sales contact - at 212.633.3766 for advertising rates for all classifieds and showcase ads.

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Don't let your patients sacrifice comfort and vision

Some eye care professionals may believe that 2-week replacement lens wearers are more compliant* than monthly replacement lens wearers, but the opposite is actually true.[1]

Studies have shown that daily disposable and monthly replacement lens wearers are the most compliant* patients.[1,2,3]

Alcon proudly offers the lens modalities that promote patient compliance* and satisfaction with our **DAILIES®** brand daily disposable and **AIR OPTIX®** brand monthly replacement contact lenses.

Visit **myalcon.com/power-of-one** or speak to your Alcon representative to learn more.

POWER OF ONE™

MORE POWER FOR GREATER SUCCESS

*Compliance with Manufacturer-Recommended Replacement Frequency (MRRF).

References: 1. Dumbleton K, Woods C, Jones L, et al. Patient and practitioner compliance with silicone hydrogel and daily disposable lens replacement in the United States. *Eye Contact Lens.* 2009;35(4):164-171. **2.** Yeung K, Forister J, Forister E, et al. Compliance with soft contact lens replacement schedules and associated contact lens-related ocular complications: The UCLA Contact Lens Study. *Optometry.* 2010; 81: 598-607.
3. Jones L, Dumbleton K, Fonn D, et al. Comfort and compliance with frequent replacement soft contact lenses. *Optom Vis Sci.* 2002;79:259.

See product instructions for complete wear, care, and safety information.

Alcon®

 6/12 POW12041JAD

℞ only

He's known for precision and outstanding performance.

So are his lenses.

A lens that provides outstanding performance with an easy fit

- Outperforms ACUVUE^ OASYS^ for ASTIGMATISM contact lenses in overall comfort, vision, and handling[1,2]**
- Precision Balance 8I4™ Lens Design allows for exceptional lens stability
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*AIR OPTIX® for Astigmatism (lotrafilcon B) contact lenses: Dk/t = 108 @ -3.00D -1.25 X 180. ^Trademarks are the property of their respective owners. **Based on patient ratings at 2 weeks.

Important information for AIR OPTIX® for Astigmatism (lotrafilcon B) contact lenses: For daily wear or extended wear up to 6 nights for near/far-sightedness, and astigmatism. Risk of serious eye problems (i.e. corneal ulcer) is greater for extended wear. In rare cases, loss of vision may result. Side effects like discomfort, mild burning or stinging may occur.

References: 1. Brobst A, Wang C, Rappon J. Clinical comparison of the visual performance of silicone hydrogel toric lenses with different stabilization systems. *Cont Lens Ant Eye.* 2009;32:243. **2.** In a subject-masked, randomized clinical study at 14 sites with 154 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2008. **3.** In a randomized, subject-masked, multi-site clinical study with over 150 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2005.

See product instructions for complete wear, care, and safety information.

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